Maricopa County

PREFERRED PROVIDER MEDICAL
BENEFITS

EFFECTIVE DATE: January 1, 2004

CN003
0025786

This document printed in December, 2003 takes the place of any documents previously issued to you which described your benefits.

Printed in U.S.A.

Table of Contents

Special Plan Provisions

When you select a Participating Provider, this plan pays a greater share of the costs than if you were to select a non-Participating Provider. Participating Providers include Physicians, Hospitals and Other Health Care Professionals and facilities. Consult your Physician Guide for a list of Participating Providers in your area. Participating Providers are committed to providing you and your Dependents appropriate care while lowering medical costs.

Services Available in Conjunction with Your Medical Plan

The following several pages describe helpful services available in conjunction with your medical plan. You can access these services simply by calling the toll-free number shown on the back of your ID card. These services are provided by Intracorp, a CIGNA Company and can help ensure that you and your covered Dependents benefit fully from your medical coverage.

FPINTRO4

CIGNA'S Toll-Free Care Line

CIGNA's toll-free care line is a service provided through Intracorp, a CIGNA company. You can talk to a health care professional during normal business hours, Monday through Friday, simply by calling the toll-free number shown on your ID Card.

CIGNA's toll-free care line personnel can provide you with the names of Participating Providers. If you or your Dependents need medical care, you may consult your Physician Guide which lists the Participating Providers in your area or call CIGNA's toll-free number for assistance. And, if you or your Dependents need medical care while away from home, you may have access to a national network of Participating Providers through CIGNA's Away-From-Home Care feature. Call CIGNA's toll-free care line for the names of Participating Providers in other network areas. Whether you obtain the name of a Participating Provider from your Physician Guide or through the care line, it is recommended that you call the provider to confirm that he or she is a current participant in the Preferred Provider Program prior to making an appointment.

FPCCL10

Case Management

Case Management is a service provided through Intracorp, a CIGNA Company, which assists individuals with treatment needs that extend beyond the acute care setting. The goal of Case Management is to ensure that patients receive appropriate care in the most effective setting possible whether at home, as an outpatient, or an inpatient in a hospital or specialized facility. Should the need for Case Management arise, a Case Management professional will work closely with the patient, his or her family and the attending physician to determine appropriate treatment options which will best meet the patient's needs and keep costs manageable. The Case Manager will help coordinate the treatment program and arrange for necessary resources. Case Managers are also available to answer questions and provide ongoing support for the family in times of medical crisis.

Intracorp Case Managers are Registered Nurses (RNs) and other credentialed health care professionals, each trained in a clinical specialty area such as trauma, high risk pregnancy and neonates, oncology, mental health, rehabilitation or general medicine and surgery. A Case Manager trained in the appropriate clinical specialty area will be assigned to you or your dependent. In addition, Case Managers are supported by a panel of physician advisors who offer guidance on up-to-date treatment programs and medical technology. While the Case Manager recommends alternate treatment programs and helps coordinate needed resources, the patient's attending physician remains responsible for the actual medical care.

1. You, your dependent or an attending physician can request Case Management services by calling the toll-free care line number shown on the back of your ID card during normal business hours, Monday through Friday. In addition, your employer, a claim office or a utilization review program may refer an individual for Case Management. (see the PAC/CSR section of your certificate)
2. Intracorp assesses each case to determine whether Case Management is appropriate.
3. You or your dependent is contacted by an assigned Case Manager who explains in detail how the program works. Participation in the program is voluntary - no penalty or benefit reduction is imposed if you do not wish to participate in Case Management.

FPCM3

4. Following an initial assessment, the Case Manager works with you, your family and Physician to determine the needs of the patient and to identify what alternate treatment programs are available. (for example, in-home medical care in lieu of an extended Hospital convalescence). You are not penalized if the alternate treatment program is not followed.
5. The Case Manager arranges for alternate treatment services and supplies, as needed. (for example, nursing services or a Hospital bed and other Durable Medical Equipment for the home).
6. The Case Manager also acts as a liaison between the insurer, the patient, his or her family and Physician as needed. (for example, by helping you to understand a complex medical diagnosis or treatment plan).
7. Once the alternate treatment program is in place, the Case Manager continues to manage the case to ensure the

treatment program remains appropriate to the patient's needs.

While participation in Case Management is strictly voluntary, Case Management professionals can offer quality, cost-effective treatment alternatives, as well as provide assistance in obtaining needed medical resources and ongoing family support in a time of need.

FPCM2

Additional Programs

CG may, from time to time, offer or arrange for various entities to offer discounts, benefits or other consideration to Employees for the purpose of promoting their general health and well being. Contact CG for details of these programs.

GM6000 PRM1

Notice of Federal Requirements

Coverage for Reconstructive Surgery Following Mastectomy

When a person insured for benefits under this certificate who has had a mastectomy at any time, decides to have breast reconstruction, based on consultation between the attending Physician and the patient, the following benefits will be subject to the same coinsurance and deductibles which apply to other plan benefits:

- reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- treatment of physical complications in all stages of mastectomy, including lymphedema; and
- mastectomy bras and external prostheses limited to the lowest cost alternative available that meets the patient's physical needs.

If you have any questions about your benefits under this plan, please call the number on your ID card or contact your employer.

Coverage for Maternity Hospital Stay

Group health plans and health insurance issuers offering group health insurance coverage generally may not, under federal law restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section, or require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of the above periods.

The law generally does not prohibit an attending provider of the mother or newborn, in consultation with the mother, from discharging the mother or newborn earlier than 48 or 96 hours, as applicable.

Please review this Plan for further details on the specific coverage available to you and your Dependents.

NOT101

Notice Regarding Provider Directories and Provider Networks

If your Plan utilizes a network of Providers, you will automatically and without charge, receive a separate listing of Participating Providers.

Your Participating Provider network consists of a group of local medical practitioners, including Hospitals, of varied specialties as well as general practice, who are employed by or contracted with CIGNA HealthCare.

NOT85

Notice of Federal Requirements Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) sets requirements for continuation of health coverage and reemployment in regard to military leaves of absence. These requirements apply to medical and dental coverage for you and your Dependents. They do not apply to any Life, Short-term or Long-term Disability or Accidental Death & Dismemberment coverage.

Continuation of Coverage

For leaves of less than 31 days, coverage will continue as described in the Termination section regarding Leave of Absence.

For leaves of 31 days or more, you may continue coverage for yourself and your Dependents as follows:

If your Employer is subject to federal continuation requirements called COBRA, you may continue benefits according to the federal continuation benefits shown in your certificate.

If your Employer is not subject to COBRA, you may continue benefits, by paying the required premium to your Employer, until the earliest of the following:

- 18 months from the last day of employment with the Employer;
- the day after you fail to apply or return to work; and
- the date the policy cancels.

Your Employer may charge you and your Dependents up to 102% of the total premium.

Following continuation of health coverage per COBRA or USERRA requirements, you may convert to a plan of individual coverage according to any "Conversion Privilege" shown in your certificate.

NOT73

Reinstatement of Benefits (applicable to all coverages)

If your coverage ends during the leave because you do not elect COBRA or an available conversion plan at the expiration of COBRA and you are reemployed by your current Employer, coverage for you and your Dependents may be reinstated if, a) you gave your Employer advance written or verbal notice of your military service leave, and b) the duration of all military leaves while you are employed with your current Employer does not exceed 5 years.

You and your Dependents will be subject to only the balance of a Pre-existing Condition Limitation (PCL) or waiting period that was not yet satisfied before the leave began. However, if an Injury or Sickness occurs or is aggravated during the military leave, full Plan limitations will apply.

Any 63-day break in coverage rule regarding credit for time accrued toward a PCL waiting period will be waived.

NOT74

Time Frames for Requesting Reemployment

When a leave ends, you must report your intent to return to work as follows:

- For leaves of less than 31 days or for a fitness exam, by reporting to your Employer by the next regularly scheduled work day following 8 hours of travel time;
- For leaves of 31 days or more but less than 181 days, by submitting an application to your Employer within 14 days; and
- For leaves of more than 180 days, by submitting an application to your Employer within 90 days.

Consult your Employer for more details regarding your rights and your Employer's obligations for re-employment.

This section will be superseded in whole or in part by any richer state-required provision shown in this certificate.

NOT104

Notice of an Appeal or a Grievance

The appeal or grievance provision in this certificate may be superseded by the law of your state. Please see your explanation of benefits for the applicable appeal or grievance procedure.

NOT90

Notice of Federal Requirements

If your income does not exceed 100% of the official poverty line and your liquid resources are at or below twice the Social Security income level, the state may decide to pay premiums for this coverage instead of for Medicaid, if it is cost-effective. This includes premiums for continuation coverage required by federal law.

NOT99

Arizona - Important Notice

This notice is to advise you that you can obtain a replacement Appeals Process Information Packet by calling the Customer Service Department at the telephone number listed on your identification card for "Claim Questions/Eligibility Verification" or for "Member Services" or by calling **1-800-251-0669.**

The Information Packet includes a description and explanation of the appeal process for CG.

NOT102

Arizona - Provider Lien Notice

Arizona law entitles health care providers to assert a lien for their customary charges for the care and treatment of an injured person upon any and all claims of liability or indemnity, except health insurance. If you are injured and have a claim against a non-health liability insurer (such as automobile or homeowner insurance) or any other payor source for injuries sustained, your health care provider may assert a lien against available proceeds from any such insurer or payor in an amount equal to the difference between the sum, if any, payable to the health care provider under this Plan and the health care provider's full billed charges.

NOT109

Home Office: Bloomfield, Connecticut
Mailing Address: Hartford, Connecticut 06152

CONNECTICUT GENERAL LIFE INSURANCE COMPANY
a CIGNA company (called CG) certifies that it insures certain Employees for the benefits provided by the following policy(s):

POLICYHOLDER: Maricopa County

GROUP POLICY(S) - COVERAGE

0025786-PPA01 PREFERRED PROVIDER MEDICAL BENEFITS

NOTICE

Any insurance benefits in this Certificate will apply to an Employee only if: (a) he has elected that benefit; and (b) he has a "Final Confirmation Letter," with his name, which shows his election of that benefit.

EFFECTIVE DATE January 1, 2004

This certificate describes the main features of the insurance. It does not waive or alter any of the terms of the policy(s). If questions arise, the policy(s) will govern.

This certificate takes the place of any other issued to you on a prior date which described the insurance.

Susan L. Cooper

Corporate Secretary

GM6000 CER7V23

Explanation of Terms

You will find terms starting with capital letters throughout your certificate. To help you understand your benefits, most of these terms are defined in the Definitions section of your certificate.

THE SCHEDULE

The Schedule is a brief outline of your maximum benefits which may be payable under your insurance. For a full description of each benefit, refer to the appropriate section listed in the Table of Contents.

Effect of Section 125 Regulations on this Plan

Your Employer has chosen to administer this Plan in accordance with Section 125 Regulations of the Internal Revenue Code. Per this regulation, you may agree to a pre-tax salary reduction put toward the cost of your benefits. Otherwise you will receive your taxable earnings as cash (salary).

Provisions in this certificate which allow for enrollment or coverage changes not consistent with Section 125 Regulations are superseded by this section.

Coverage Elections

Per Section 125 Regulations, you are generally allowed to enroll for or change coverage only before each annual benefit period. However, exceptions are allowed if you enroll for or change coverage within 30 days of the following:

Special Enrollment

Special Enrollment per federal requirements as described in the Section entitled "Eligibility - Effective Date/Exception to Late Entrant Definition" **if** included in this document.

SCT125V1

Change in Status

A change in coverage due to the following changes in status: a) change in legal marital status due to marriage, death of a spouse, divorce, annulment or legal separation; b) change in number of dependents due to birth, adoption, placement for adoption or death of a dependent; c) change in employment status of Employee, spouse or dependent due to termination or start of employment, strike, lockout, beginning or end of unpaid leave of absence, including under Family and Medical Leave Act (FMLA) or change in worksite; d) changes in employment status of Employee, spouse or dependent resulting in eligibility or ineligibility for coverage; e) change in residence of Employee, spouse or dependent; and f) changes which cause a dependent to become eligible or ineligible for coverage.

Any changes in coverage must pertain directly to the change in status.

Court Order

A change in coverage due to and consistent with a court order of the Employee or other person to cover a dependent.

Medicare Eligibility/Entitlement

The Employee, spouse or dependent cancels or reduces coverage due to entitlement to Medicare, or enrolls or increases coverage due to loss of Medicare eligibility.

Change in Cost of Coverage

If the cost of benefits increases or decreases during a benefit period, your Employer may in accordance with plan terms automatically change your elective contribution.

When the change in cost is significant, you may either increase your contribution or elect less-costly coverage. When a significant overall reduction is made to the benefit option you have elected, you may elect another available benefit option. When a new benefit option is added, you may change your election to the new benefit option.

Changes in Coverage of Spouse or Dependent under Another Employer's Plan

You may make a coverage election change if the plan of your spouse or dependent: a) incurs a change such as adding or deleting a benefit option; b) allows election changes due to Special Enrollment, Change in Status, Court Order or Medicare Eligibility/Entitlement; or c) this Plan and the other plan have different periods of coverage.

SCT125V2

How to File Your Claim

The prompt filing of any required claim form will result in faster payment of your claim.

You may get the required claim forms from your Benefit Plan Administrator. All fully completed claim forms and bills should be sent directly to your servicing CG Claim Office.

Depending on your Group Insurance Plan benefits, file your claim forms as described below.

Hospital Confinement

If possible, get your Group Medical Insurance claim form before you are admitted to the Hospital. This form will make your admission easier and any cash deposit usually required will be waived.

If you have a Benefit Identification Card, present it at the admission office at the time of your admission. The card tells the Hospital to send its bills directly to CG.

Doctor's Bills and Other Medical Expenses

The first Medical Claim should be filed as soon as you have incurred covered expenses. Itemized copies of your bills should be sent with the claim form. If you have any additional bills after the first treatment, file them periodically.

CLAIM REMINDERS

- BE SURE TO USE YOUR SOCIAL SECURITY AND ACCOUNT NUMBER WHEN YOU FILE CG'S CLAIM FORMS, OR WHEN YOU CALL YOUR CG CLAIM OFFICE.

  YOUR ACCOUNT NUMBER IS THE 7-DIGIT POLICY NUMBER SHOWN ON YOUR BENEFIT IDENTIFICATION CARD.

- PROMPT FILING OF ANY REQUIRED CLAIM FORMS RESULTS IN FASTER PAYMENT OF YOUR CLAIMS.

WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to fines and confinement in prison.

GM6000 CI 3 CLA9V31

Accident and Health Provisions

Claims

Notice of Claim

Written notice of claim must be given to CG within 30 days after the occurrence or start of the loss on which claim is based. If notice is not given in that time, the claim will not be invalidated or reduced if it is shown that written notice was given as soon as was reasonably possible.

Claim Forms

When CG receives the notice of claim, it will give to the claimant, or to the Policyholder for the claimant, the claim forms which it uses for filing proof of loss. If the claimant does not get these claim forms within 15 days after CG receives notice of claim, he will be considered to meet the proof of loss requirements of the policy if he submits written proof of loss within 90 days after the date of loss. This proof must describe the occurrence, character and extent of the loss for which claim is made.

Proof of Loss

Written proof of loss must be given to CG within 90 days after the date of the loss for which claim is made. If written proof of loss is not given in that time, the claim will not be invalidated nor reduced if it is shown that written proof of loss was given as soon as was reasonably possible.

Physical Examination

CG, at its own expense, will have the right to examine any person for whom claim is pending as often as it may reasonably require.

Legal Actions

Where CG has followed the terms of the policy, no action at law or in equity will be brought to recover on the policy until at least 60 days after proof of loss has been filed with CG. No action will be brought at all unless brought within 3 years after the time within which proof of loss is required.

GM6000 PRO1 CLA43V6

Eligibility - Effective Date

Eligibility for Employee Insurance

You will become eligible for insurance on the day you complete the waiting period if:

- you are in a Class of Eligible Employees; and
- you are an eligible, full-time Employee; or
- you normally work at least 40 hours per pay period; or
- you are an eligible retiree

If you were previously insured and your insurance ceased, you must satisfy the New Employee Group Waiting Period to become insured again. If your insurance ceased because you were no longer employed in a Class of Eligible Employees, you are not required to satisfy any waiting period if you again become a member of a Class of Eligible Employees within one year after your insurance ceased.

Initial Employee Group: You are in the Initial Employee Group if you are employed in a class of employees on the date that class of employees becomes a Class of Eligible Employees as determined by your Employer.

New Employee Group: You are in the New Employee Group if you are not in the Initial Employee Group.

Eligibility for Dependent Insurance

You will become eligible for Dependent insurance on the later of:

- the day you become eligible for yourself; or
- the day you acquire your first Dependent.

Waiting Period

Initial Employee Group: None

New Employee Group: First of the month following Date of Hire.

Classes of Eligible Employees

All Eligible Full-Time and Part-Time Employees, Retirees and Dependents.

GM6000 EL 2 V-31
ELI5M

Employee Insurance

This plan is offered to you as an Employee. To be insured, you will have to pay part of the cost.

Effective Date of Your Insurance

You will become insured on the date you elect the insurance by signing an approved payroll deduction form, but no earlier than the date you become eligible. If you are a Late Entrant, your insurance will not become effective until CG agrees to insure you. You will not be denied enrollment for Medical Insurance due to your health status.

You will become insured on your first day of eligibility, following your election, if you are in Active Service on the date, or if you are not in Active Service on that date due to your health status. However, you will not be insured for any loss of life, dismemberment or loss of income coverage until you are in Active Service.

Late Entrant - Employee

You are a Late Entrant if:

- you elect the insurance more than 30 days after you become eligible; or
- you again elect it after you cancel your payroll deduction.

GM6000 EF 1 ELI7V82 DG

Exception to Late Entrant Definition

A person will not be considered a Late Entrant when enrolling outside a designated enrollment period if: he had existing coverage, and he certified in writing, if applicable, that he declined coverage due to such coverage; he lost prior coverage due to the employer's failure to pay premium; he is no longer eligible for prior coverage; or if such prior coverage was continuation coverage and the continuation period has been exhausted and he enrolls for this coverage within 30 days after losing or exhausting prior coverage; or if he is a Dependent spouse or minor child enrolled due to a court order within 30 days after the court order is issued.

If you acquire a new Dependent through marriage, birth, adoption or placement for adoption, you may enroll your eligible Dependents and yourself, if you are not already enrolled, within 30 days of such event. Coverage will be effective on the date of marriage, birth, adoption, or placement for adoption.

Any applicable Pre-existing Condition limitation will apply to you and your Dependents upon enrollment, reduced by prior Creditable Coverage, but will not be extended as for a Late Entrant.

Pre-Existing Condition Limitation for Late Entrant

For plans which include a Pre-existing Condition limitation, the one-year waiting period before coverage begins for such condition will be increased to 18 months for a Late Entrant.

For plans which do not include a Pre-existing Condition limitation, you may be required to wait until the next plan enrollment period to enroll for coverage under the plan, if you are a Late Entrant.

For plans which do not standardly include a Pre-existing Condition limitation and which do not include an annual open enrollment period, a Pre-existing Condition limitation of 18 months will apply for a Late Entrant only.

GM6000 EL 1 ELI7V55M

Dependent Insurance

For your Dependents to be insured, you will have to pay part of the cost of Dependent Insurance.

Effective Date of Dependent Insurance

Insurance for your Dependents will become effective on the date you elect it by signing an approved payroll deduction form, but no earlier than the day you become eligible for Dependent Insurance. All of your Dependents as defined will be included.

If you are a Late Entrant for Dependent Insurance, the insurance for each of your Dependents will not become effective until CG agrees to insure that Dependent. Your Dependent will not be denied enrollment for Medical Insurance due to health status.

Your Dependents will be insured only if you are insured.

Late Entrant - Dependent

You are a Late Entrant for Dependent Insurance if:

- you elect that insurance more than 30 days after you become eligible for it; or
- you again elect it after you cancel your payroll deduction.

CG may require evidence of your Dependent's good health at your expense if you are a Late Entrant. Such requirement will not apply to Medical Insurance.

Exception for Newborns

Any Dependent child born while you are insured for Medical Insurance will become insured for Medical Insurance on the date of his birth if you elect Dependent Medical Insurance no later than 31 days after his birth. If you do not elect to insure your newborn child within such 31 days, coverage for that child will end on the 31st day. No benefits for expenses incurred beyond the 31st day will be payable.

GM6000 EF 2 ELI11V44M

Requirements of the Omnibus Budget Reconciliation Act of 1993 (OBRA '93)

These health coverage requirements do not apply to any benefits for loss of life, dismemberment or loss of income.

Any other provisions in this certificate that provide for: (a) the definition of an adopted child and the effective date of eligibility for coverage of that child; and (b) eligibility requirements for a child for whom a court order for medical support is issued; are superceded by these provisions required by the federal Omnibus Budget Reconciliation Act of 1993, where applicable.

A. Eligibility for Coverage under a Qualified Medical Child Support Order

If a Qualified Medical Child Support Order is issued for your child, that child will be eligible for coverage as required by the order and you will not be considered a Late Entrant for Dependent Insurance.

You must notify your Employer and elect coverage for that child, and yourself if you are not already enrolled, within 31 days of the Qualified Medical Child Support Order being issued.

Qualified Medical Child Support Order

A Qualified Medical Child Support Order is a judgement, decree or order (including approval of a settlement agreement) or administrative notice, which is issued pursuant to a state domestic relations law (including a community property law), or to an administrative process, which provides for child support or provides for health benefit coverage to such child and relates to benefits under the group health plan, and satisfies all of the following:

(1) the order recognizes or creates a child's right to receive group health benefits for which a participant or beneficiary is eligible;

(2) the order specifies your name and last known address, and the child's name and last known address, except that the name and address of an official of a state or political subdivision may be substituted for the child's mailing address;

(3) the order provides a description of the coverage to be provided, or the manner in which the type of coverage is to be determined;

(4) the order states the period to which it applies; and

(5) if the order is a National Medical support Notice completed in accordance with the Child Support Performance and Incentive Act of 1998, such Notice meets the requirements above.

OBRA1

The Qualified Medical Child Support Order may not require the health insurance policy to provide coverage for any type or form of benefit or option not otherwise provided under the policy, except an order may require a plan to comply with States laws regarding child health care coverage.

Payment of Benefits

Any payment of benefits in reimbursement for Covered Expenses paid by the child, the child's custodial parent or legal guardian, shall be made to the child, the child's custodial parent or legal guardian, or a state official whose name and address have been substituted for the name and address of the child.

B. Eligibility for Coverage for Adopted Children

Any child under the age of 18 who is adopted by you, including a child who is placed with you for adoption, will be eligible for Dependent Insurance upon the date of placement with you. A child will be considered placed for adoption when you become legally obligated to support that child, totally or partially, prior to that child's adoption.

If a child placed for adoption is not adopted, all health coverage ceases when the placement ends, and will not be continued.

The provisions in the "Exceptions for Newborns" section of this certificate that describe requirements for enrollment and effective date of insurance will also apply to an adopted child or a child placed with you for adoption.

Any "Pre-existing Condition Limitation" in this certificate will be waived for an adopted child or a child placed for adoption.

OBRA2

Comprehensive Medical Benefits

The Schedule

For You and Your Dependents

This plan provides medical benefits for services and supplies provided by Participating Providers and Non-Participating Providers, unless otherwise noted. To receive Preferred Provider Medical Benefits, you and your Dependents may be required to pay a portion of the Covered Expenses for services and supplies. That portion is the Copayment, Deductible or Coinsurance.

You or your Dependent can obtain the names of Participating Providers in your area by consulting your Physician Guide, or calling the toll-free number shown on the back of your I.D. card.

If you are unable to locate a Participating Provider in your area who can provide you with a service or supply that is covered under this plan, you must call the number on the back of your I.D. card to obtain authorization for Non-Participating Provider coverage. If you obtain authorization for services provided by a Non-Participating Provider, benefits for those services will be covered at the Participating Provider benefit level.

Plan Maximum Benefits	This Plan will Pay:	
	Participating Provider	**Non-Participating Provider**
Lifetime Maximum Benefit	Unlimited	$5,000,000
Transplant Travel Benefit to a LifeSource Facility (Not included in Lifetime or Calendar Year Limits)	$10,000	Not Covered

Calendar Year Deductible

Deductibles are expenses to be paid by an Employee or Dependent for the services rendered. These Deductibles are in addition to any copayments or coinsurance.

Plan Deductibles	You Pay:	
	Participating Provider	**Non-Participating Provider**
Individual Deductible	$250 per person	$750 per person

Family Deductible	$500 per family After Participating Provider Deductibles totaling $500 have been applied in a Calendar Year for either (a) you and your Dependents or (b) your Dependents, your family need not satisfy any further Medical Deductibles for the rest of that year.	$1,500 per family After Non-Participating Provider Deductibles totaling $1,500 have been applied in a Calendar Year for either (a) you and your Dependents or (b) your Dependents, your family need not satisfy any further Medical Deductible for the rest of that year.

Out-of-Pocket Expenses

Out-of-Pocket Expenses are Covered Expenses incurred for Participating Provider and Non-Participating Provider charges for which no payment is provided because of the coinsurance factor. However, charges for Covered Expenses incurred for or in connection with non-compliance penalties or in excess of Reasonable & Customary levels will not accumulate toward the Out-of -Pocket Maximums and benefits for such expenses will not be increased by the terms of the "Full Payment" section.

Out-of-Pocket Maximums	**You Pay:**	
	Participating Provider	**Non-Participating Provider**
Individual Out-of-Pocket Maximum	$2,000 per person	$4,000 per person
Family Out-of-Pocket Maximum	$6,000 per family After Participating Provider Out-of-Pocket Expenses totaling $6,000 have been incurred in a Calendar Year for either (a) you and your Dependents or (b) your Dependents, your family need not satisfy any further Out-of-Pocket Expenses for the rest of that year.	$12,000 per family After Non-Participating Provider Out-of-Pocket Expenses totaling $12,000 have been incurred in a Calendar Year for either (a) you and your Dependents or (b) your Dependents, your family need not satisfy any further Out-of-Pocket Expenses for the rest of that year.

Simultaneous Accumulation of Deductibles and Out-of-Pocket

Expenses incurred for either Participating Provider or Non-Participating Provider charges will be used to satisfy both the Participating Provider Deductibles and Out-of-Pocket Maximums and the Non-Participating Provider Deductibles and Out-of-Pocket Maximums simultaneously, until the Participating Provider Deductibles and Out-of-Pocket Maximums have been satisfied. However, only expenses incurred for Non-Participating Provider charges will be used to satisfy the remainder of the Non-Participating Provider Deductibles and Out-of-Pocket Maximums.

Benefits for care	How this Plan Works:	
	Participating Provider	**Non-Participating Provider**
	You and your Dependent pay the Participating Provider Deductible or Copayments and any benefit deductible shown below plus the Coinsurance, then the Plan pays the Benefit Percentage shown	You and your Dependent pay the Non-Participating Provider Deductibles or Copayments and any benefit deductible shown below plus the Coinsurance, then the Plan pays the Benefit Percentage shown
Physician Services		
Physician Office Visit	80% after plan deductible; 80% after deductible for x-ray/lab if billed by separate facility	60% after plan deductible
Specialty Care Physician Office Visit	80% after plan deductible; 80% after deductible for x-ray/lab if billed by separate facility	60% after plan deductible
Surgery Performed in the Physician's Office	80% after plan deductible; 80% after deductible for x-ray/lab if billed by separate facility	60% after plan deductible
Allergy Treatment/Injections Allergy Serum/Antigens	80% after plan deductible	60% after plan deductible
Preventive Care		
Annual Routine Physicals and Immunizations through age 2	80% after plan deductible; 80% after deductible for x-ray/lab if billed by separate facility	Not Covered
Annual Routine Physicals, Immunization and Well-Woman Coverage age 3 and above (Includes Pap Test, PSA. etc.)	80% after plan deductible; 80% after deductible for x-ray/lab if billed by separate facility	Not Covered

Mammogram	80% after plan deductible; 80% after deductible for x-ray/lab if billed by separate facility	60% after plan deductible

Pre-Admission Testing		
Physician Office Visit	80% after plan deductible for x-ray and lab work done in Physician's office, however if other office visit services are provided, the visit will be paid the same as any other office visit	60% after plan deductible
Specialist Physician Office Visit	80% after plan deductible for x-ray and lab work done in Specialist's office, however if other office visit services are provided, the visit will be paid the same as any other Specialist office visit	60% after plan deductible
Outpatient Facility	80% after plan deductible for x-ray and lab work done at an Outpatient Facility. Any copays for MRI/PET/CAT scans will continue to apply	60% after plan deductible
Independent Lab and X-Ray Facility	80% after plan deductible	60% after plan deductible

Inpatient Hospital Facility Services	80% after plan deductible	60% after plan deductible
Semi Private Room and Board	The Hospital's negotiated rate	The Hospital's most common daily rate for a semi-private room
Private Room and Board	The Hospital's negotiated rate for a semi-private room	The Hospital's most common daily rate for a semi-private room
Special Care Units (ICU/CCU) and Board	The Hospital's negotiated rate	

Outpatient Hospital Facility Services	80% after plan deductible	60% after plan deductible
Operating Room, Recovery Room, Procedure Room, and Treatment		

Inpatient Hospital Doctor's Visits/Consultations	80% after plan deductible	60% after plan deductible
Inpatient Hospital Professional Services: Surgeon Radiologist Pathologist Anesthesiologist	80% after plan deductible	60% after plan deductible
Outpatient Professional Services Surgeon Radiologist Pathologist Anesthesiologist	80% after plan deductible	60% after plan deductible

Second Opinions (Services will be provided on a voluntary basis)	80% after plan deductible	60% after plan deductible

Emergency and Urgent Care Services		
Physician's Office	Same as Physician's Office Visit	Same as Physician's Office Visit;
Hospital Emergency Room	$100 per visit, then 100% *	$100 per visit, then 100% *; if not a true emergency, then 60% after plan deductible
Urgent Care Facility or Outpatient Facility	$50 per visit, then 100% *	$50 per visit, then 100% *; if not a true emergency, then 60% after plan deductible
Ambulance	90% after plan deductible	90% after plan deductible ; if not a true emergency, then 60% after plan deductible
	*Waived if Admitted	*Waived if Admitted

Skilled Nursing		
Skilled Nursing Facility Services	80% after plan deductible	60% after plan deductible
Skilled Nursing Room and Board	The Skilled Nursing Facility's negotiated rate	The Skilled Nursing Facility's most common daily rate for a semi-private room
Calendar Year Maximum: 90 days		

Laboratory and Radiology Services		
MRIs, MRAs, CAT Scans and PET Scans	80% after plan deductible	60% after plan deductible
Other Laboratory and Radiology Services (All charges billed by an independent facility)	80% after plan deductible	60% after plan deductible

Home Health Care	80% after plan deductible Calendar Year Maximum: Unlimited	60% after plan deductible Calendar Year Maximum: 40 Visits

Hospice		
Inpatient Facility	80% after plan deductible	60% after plan deductible
Outpatient Facility (Same as Home Health Care Coinsurance)	Same as plan's Outpatient Hospital Facility Benefit	Same as plan's Outpatient Hospital Facility Benefit
Hospice Room and Board	The Hospice Facility's negotiated rate	The Hospice Facility's most common daily rate for a semi-private room
Calendar Year Maximum: Unlimited		

Outpatient Short-Term Rehabilitative Therapy Calendar Year Maximum: 60 days per calendar year, all Therapies combined Includes: Cardiac Rehab Physical Therapy Speech Therapy Occupational Therapy	80% after plan deductible	60% after plan deductible

Chiropractic/Osteopathic Care Calendar Year Maximum: Unlimited	80% after plan deductible	60% after plan deductible
Maternity		
Initial Visit to Confirm Pregnancy	80% after plan deductible	60% after plan deductible
All Subsequent Physician's charges for Prenatal Visits, Postnatal Visits, and Delivery	No Charge	60% after plan deductible
Delivery (Inpatient Hospital, Birthing Center)	Same as plan's Inpatient Hospital Facility Benefit	Same as plan's Inpatient Hospital Facility Benefit

Family Planning		
Office Visits including Tests and Counseling (Includes IUD's, Depo Provera, Norplant and Diaphragms if administered in Doctor's Office)	80% after plan deductible	60% after plan deductible
Surgical Sterilization Procedures for Vasectomy/Tubal Ligations (excluding reversals)		
Inpatient Facility	Same as plan's Inpatient Hospital Facility Benefit	Same as plan's Inpatient Hospital Facility Benefit
Outpatient Facility	Same as plan's Outpatient Hospital Facility Benefit	Same as plan's Outpatient Hospital Facility Benefit
Physician's Services	80% after plan deductible	60% after plan deductible

Infertility Treatment		
Office Visit (Tests, Counseling)	Same as plan's Specialist Physician Office Visit	Same as plan's Specialist Physician Office Visit
Surgical Treatment: Limited to Procedures for Correction of Infertility (excludes In Vitro Fertilization, GIFT, ZIFT, and similar procedures) (Includes Artificial Insemination)	80% after plan deductible	60% after plan deductible
Inpatient Facility	Same as plan's Inpatient Hospital Facility Benefit	Same as plan's Inpatient Hospital Facility Benefit
Outpatient Facility	Same as plan's Outpatient Hospital Facility Benefit	Same as plan's Outpatient Hospital Facility Benefit
Physician's Services	80% after plan deductible	60% after plan deductible

Organ Transplants Includes all medically appropriate non-experimental transplants		
Lifesource Facility	100%, no deductible	Not Covered
Lifetime Maximum: Unlimited		
Other Inpatient Hospital Facility	Same as plan's Inpatient Hospital Facility benefit	Not Covered
Physician's Services		
Lifesource Physician	No Charge	Not Covered
Non-Lifesource Physician	80% after plan deductible	Not Covered

Travel Services Maximum (Covered only when transplant procedure is performed at a Lifesource Facility) Lifetime Maximum: $10,000	100%, no deductible	Not Covered

Durable Medical Equipment Calendar Year Maximum: $700	80% after plan deductible	60% after plan deductible

External Prosthetic Appliances Calendar Year Maximum: $1,000 Separate $200 deductible per calendar year applies	80% after plan deductible	60% after plan deductible

Dental Care (Limited to charges made for a continuous course of dental treatment started within six months of an injury to sound, natural teeth)		
Inpatient Facility	Same as plan's Inpatient Hospital Facility benefit	Same as plan's Inpatient Hospital Facility benefit
Outpatient Facility	Same as plan's Outpatient Hospital Facility benefit	Same as plan's Outpatient Hospital Facility benefit
Physician's Services	80% after plan deductible	60% after plan deductible

Temporomandibular Joint Disorder (Surgical & Non-Surgical Treatment)		
Office Visit	80% after plan deductible	60% after plan deductible
Inpatient Facility	Same as plan's Inpatient Hospital Facility Benefit	60% after plan deductible
Outpatient Facility	Same as plan's Outpatient Hospital Facility Benefit	60% after plan deductible
Physician's Services	80% after plan deductible	60% after plan deductible
Lifetime Maximum: $600		

Alternative Medicine Services* Outpatient (Limited to 6 self-referral visits per calendar year) *Covered Services include only the following services: Physician assessment, acupuncture, acupressure, physical medicine, guided imagery, massage therapy, biofeedback, and such other services as may be specifically approved by the health plan Medical Director.	$5 copay per visit, then 100%	Not Covered

Herbal or Homeopathic Products ($60 maximum per calendar year)	100%, no deductible	Not Covered

Ostomy Supplies and Urinary Catheters	100%, no deductible	Not Covered

Hearing Aids (Maximum: $2,200 every 3 years. Must be obtained at a CMG facility. Includes exam for hearing aids. Excludes coverage for loss or misuse of old hearing aid)	100%, no deductible	Not Covered

All Other Covered Expenses	80% after plan deductible	60% after plan deductible

Comprehensive Medical Benefits

For You and Your Dependents

Pre-Admission Certification/Continued Stay Review

Pre-Admission Certification (PAC) and Continued Stay Review (CSR) refer to the process used to certify the medical necessity and length of any Hospital Confinement as a registered bed patient. PAC and CSR are performed through a utilization review program by a Review Organization with which CG has contracted. PAC should be requested by you or your Dependents for each inpatient Hospital admission. CSR should be requested, prior to the end of the certified length of stay, for continued inpatient Hospital Confinement.

Expenses incurred for which benefits would otherwise be paid under this plan will not include:

- the first $400 of Hospital charges made for each separate admission to the Hospital as a registered bed patient unless PAC is received: (a) prior to the date of admission; or (b) in the case of an emergency admission, by the end of the second scheduled work day after the date of admission;
- Hospital charges for Bed and Board, during a Hospital Confinement for which PAC is performed, which are made for any day in excess of the number of days certified through PAC or CSR;
- any Hospital charges made during any Hospital Confinement as a registered bed patient: (a) for which PAC was performed; but (b) which was not certified as medically necessary.

GM6000 SC1 PAC1 SPC13V5M

In any case, those expenses incurred for which payment is excluded by the terms set forth above will not be considered as expenses incurred for the purpose of any other part of this plan, except for the "Coordination of Benefits" section.

You should start the PAC process by calling the Review Organization prior to an elective admission, or in the case of an emergency admission, by the end of the second scheduled work day after the admission. For an admission due to pregnancy, you should call the Review Organization by the end of the third month of pregnancy. The Review Organization will continue to monitor the confinement until you are discharged from the Hospital. The results of the review will be communicated to you, the attending Physician, and CG.

The Review Organization is an organization with a staff of Registered Graduate Nurses and other trained staff members who perform the PAC and CSR process in conjunction with consultant Physicians.

GM6000 SC1 PAC2 SPC15V65M

Benefit Percentage/Maximums

If, while insured for these benefits, you or any one of your Dependents incurs Covered Expenses, CG will pay an amount determined as follows:

> The Benefit Percentage of Covered Expenses incurred as shown in The Schedule, after deducting any Comprehensive Medical Deductible shown in The Schedule from the Covered Expenses first incurred for a person in each calendar year.

Payment of any benefits will be subject to any applicable deductibles and maximum benefits shown in The Schedule and the Maximum Benefit Provision.

GM6000 CM1 COM299V37M

Full Payment Area -
For Participating Provider Expenses

When a person has incurred Out-of-Pocket Expenses of $2,000 in a calendar year, benefits for him for Covered Expenses incurred for charges made by a Participating Provider during the rest of that calendar year will be payable at the rate of 100%.

When you and at least two of your Dependents or at least three of your Dependents have incurred a combined amount of Out-of-Pocket Expenses of $6,000 in a calendar year, benefits for you and all of your Dependents for Covered Expenses incurred for charges made by a Participating Provider during the rest of that calendar year will become payable at the rate of 100%.

All benefit deductibles will continue to apply. Any Comprehensive Medical Deductible, if not yet satisfied, will continue to apply until it is satisfied.

Full Payment Area -
For Non-Participating Provider Expenses

When a person has incurred Out-of-Pocket Expenses of $4,000 in a calendar year, benefits for him for Covered Expenses incurred for charges made by a non-Participating Provider during the rest of that calendar year will be payable at the rate of 100%.

When you and at least two of your Dependents or at least three of your Dependents have incurred a combined amount of Out-of-Pocket Expenses of $12,000 in a calendar year, benefits for you and all of your Dependents for Covered Expenses incurred for charges made by a non-Participating Provider during the rest of that calendar year will become payable at the rate of 100%.

All benefit deductibles will continue to apply. Any Comprehensive Medical Deductible, if not yet satisfied, will continue to apply until it is satisfied.

Out-of-Pocket Expenses

Out-of-Pocket Expenses are Covered Expenses incurred for charges made by both Participating and non-Participating Providers for which no payment is provided because of any Copayments, any Comprehensive Medical Deductible (including any benefit deductibles) and the coinsurance factor.

GM6000 CM3 COM328V76 DG

Maximum Benefit Provision

The total amount of Comprehensive Medical Benefits payable for all expenses incurred during a person's lifetime will not exceed the Maximum Benefit shown in The Schedule.

GM6000 COM360 V13M

Covered Expenses

The term Covered Expenses means the expenses incurred by or on behalf of a person for the charges listed below, if they are incurred after he becomes insured for these benefits. Expenses incurred for such charges are considered Covered Expenses to the extent that the services or supplies provided are recommended by a Physician and are essential for the necessary care and treatment of an Injury or Sickness.

Covered Expenses

- charges made by a Hospital, on its own behalf, for Bed and Board and other Necessary Services and Supplies; except that for any day of Hospital Confinement in a private room, Covered Expenses will not include that portion of charges for Bed and Board which is more than the Bed and Board Daily Limit shown in The Schedule.
- charges for licensed ambulance service to or from the nearest Hospital where the needed medical care and treatment can be provided.
- charges made by a Hospital, on its own behalf, for medical care and treatment received as an outpatient.
- charges made by a Free-standing Surgical Facility, on its own behalf, for medical care and treatment.
- charges made by a Skilled Nursing Facility, on its own behalf, for medical care and treatment; except that Covered Expenses will not include that portion of charges which is more than the Skilled Nursing Facility Limit shown in The Schedule.
- charges incurred at birth for the delivery of a child only to the extent that they exceed the birth mother's coverage, if any, provided: a) that child is legally adopted by you within one year from date of birth; b) you are legally obligated to pay the cost of the birth; c) you notify CG of the adoption within 60 days after approval of the adoption or a change in the insurance policies, plans or company; and d) you choose to file a claim for such expenses subject to all other terms of these medical benefits.

GM6000 CM5 COM169V33M

- charges made by a Physician for professional services.
- charges made by a Nurse for professional services.
- charges made for anesthetics and their administration; diagnostic x-ray and laboratory examinations; x-ray, radium, and radioactive isotope treatment; chemotherapy; blood transfusions and blood not donated or replaced; oxygen and other gases and their administration; rental or, at CG's option, purchase of Durable Medical Equipment; therapy provided by a licensed physical, occupational or speech therapist; prosthetic appliances; prostheses following a mastectomy; dressings; and drugs and medicines lawfully dispensed only upon the written prescription of a Physician while confined in a hospital.
- charges made by a Home Health Care Agency for any home health service which a Physician has prescribed in place of Hospital service, provided the service would qualify as a Covered Expense if performed in a Hospital.
- in connection with mammograms for breast cancer screening performed on dedicated equipment for diagnostic purposes on referral by a patient's Physician, not fewer than: (a) a baseline mammogram for women age 35 to 39, inclusive; (b) a mammogram for women age 40 to 49, inclusive, every two years or more frequently based on the attending Physician's recommendation; or (c) a mammogram every year for women age 50 and over.

GM6000 CM6 COM344V2M

- charges made for or in connection with approved organ transplant services, including immunosuppressive medication; organ procurement costs; and donor's medical costs. The amount payable for donor's medical costs will be reduced by the amount payable for those costs from any other Plan. Certain transplants will not be covered based on General Limitations. Contact CG before you incur any such costs.
- charges made by a Participating Provider for visits for routine preventive care of a Dependent child during the first two years of that Dependent child's life, including immunizations.
- charges made by a Participating Provider for: (a) an annual routine physical examination; (b) immunizations; and (c) Papanicolaou laboratory screening tests.

- coverage for reconstructive breast surgery following a mastectomy. The breast that had the mastectomy as well as the unaffected breast will be covered in order to provide a symmetrical appearance. It will also include prostheses and treatment of physical complications, including lymphedemas, at all stages of mastectomy. Coverage will be provided in a manner determined to be appropriate by the Physician in consultation with the insured.
- charges for off label cancer drugs that have been prescribed for a specific type of cancer for which use of the drug has not been approved by the U.S. Food and Drug Administration (U.S. FDA). Such drugs will be covered if: (a) the drug is recognized as safe and effective for treatment of the specific type of cancer in one of the standard medical reference compendia or in medical literature. Coverage will also be provided for any medical services necessary to administer the drug.

GM6000 CM71 COM351V13

- charges made for nonsurgical care for TMJ and related care, which includes care for: (a) Temporomandibular Joint and Craniomandibular Joint Disorders; and (b) other conditions of the joints linking the jawbone and skull, including the complex of muscles, nerves and other tissues related to that joint. This does not include dental work such as, but not limited to orthodontics, fixed or removable bridgework/dentures, inlays, onlays, crowns or equilibrations, whether done for dental or medical reasons. Covered Expenses will not include that portion which is more than the maximum shown in The Schedule.
- alternative medicine services coverage will be provided for certain outpatient alternative medicine services received from a designated alternative medicine center or other participating health professional which are considered to be appropriate and preferable options to standard medical intervention. Coverage will also be provided for herbal or homeopathic products available at or through a designated alternative medicine center. Services for an insured may be authorized by a participating physician, or the insured may obtain the services from a designated alternative medicine center without authorization for up to six (6) visits per calendar year.
- alternative medicine covered services include only the following services: physician assessment, acupuncture, acupressure, physical medicine, guided imagery, massage therapy, biofeedback, and such other services as maybe specifically approved by the health plan medical director; herbal and homeopathic products which are approved by the health plan are covered when obtained at the designated alternative medicine center. The retail cost of these products will not exceed the maximum shown in the Schedule.
- for rehabilitative therapy by a licensed physical, occupational or speech therapist, on an outpatient basis not to exceed the maximum shown in the Schedule.
- for charges made for voluntary family planning, including medical history, physical examination, related laboratory tests, medical supervision in accordance with general accepted medical practice, other medical services, information and counseling on contraception, oral contraceptives and contraceptive devices excluding injectible/implantable contraceptives, and after appropriate counseling, medical services connected with surgical therapies, including vasectomy, and tubal ligation.
- for charges for ostomy supplies and urinary catheters.
- for or in connection with artificial insemination.

GM6000 CM5 COM439M

The following benefits will apply to insulin and non-insulin dependent diabetics as well as covered individuals who have elevated blood sugar levels due to pregnancy or other medical conditions:

- charges for Durable Medical Equipment, including glucagon emergency kits and podiatric appliances, related to diabetes. A special maximum will not apply.
- charges for insulin; syringes; prefilled insulin cartridges for the blind; oral blood sugar control agents; glucose test strips; visual reading ketone strips; urine test strips; lancets; and alcohol swabs.
- charges for training by a Physician, including a podiatrist with recent education in diabetes management, but limited to the following:

  (a) Medically Necessary visits when diabetes is diagnosed;

  (b) visits following a diagnosis of a significant change in the symptoms or conditions that warrant change in self-management;

  (c) visits when reeducation refresher training is prescribed by the Physician; and

  (d) medical nutrition therapy related to diabetes management.

GM6000 CM65 COM342V409M

- charges made due to Terminal Illness for the following Hospice Care Services provided under a Hospice Care Program:
  - by a Hospice Facility for Bed and Board and Services and Supplies, except that, for any day of confinement in a private room, Covered Expenses will not include that portion of charges which is more than the

Hospice Bed and Board Limit shown in The Schedule;

- by a Hospice Facility for services provided on an outpatient basis;
- by a Physician for professional services;
- for pain relief treatment, including drugs, medicines and medical supplies;
- by a Home Health Care Agency for:
  - part-time or intermittent nursing care by or under the supervision of a Nurse;
  - part-time or intermittent services of a Home Health Aide;

GM6000 CM34 COM141M

  - physical, occupational, and speech therapy;
  - medical supplies; drugs and medicines lawfully dispensed only on the written prescription of a Physician; and laboratory services; but only to the extent that such charges would have been payable under the policy if the person had remained or been Confined in a Hospital or Hospice Facility.

The following charges for Hospice Care Services are not included as Covered Expenses:

- for the services of a person who is a member of your family or your Dependent's family or who normally resides in your house or your Dependent's house;
- for any period when you or your Dependent is not under the care of a Physician;
- for services and supplies not listed in the Hospice Care Program;
- for any curative or life-prolonging procedures;
- to the extent that any other benefits are payable for those expenses under the policy;
- for services or supplies that are primarily to aid you or your Dependent in daily living.

GM6000 CM35 COM143M

Expenses Not Covered

Covered Expenses will not include, and no payment will be made for, expenses incurred:

- for or in connection with cosmetic surgery unless: (a) a person receives an Injury which results in bodily damage requiring the surgery; (b) it qualifies as reconstructive surgery performed on a person following surgery, and both the surgery and the reconstructive surgery are essential and medically necessary; or (c) it is performed on any one of your Dependents who has not reached skeletal maturity.
- for hearing aids, except under Covered Expenses in The Schedule, or for eyeglasses or examinations for prescription or fitting thereof, except that Covered Expenses will include the purchase of the first pair of eyeglasses or contact lenses that follows cataract surgery.
- for or in connection with treatment of the teeth or periodontium unless such expenses are incurred for: (a) charges made for a continuous dental treatment started within six months of an Injury to sound natural teeth; (b) charges made by a Hospital for Bed and Board or Necessary Services and Supplies; or (c) charges made by the outpatient department of a Hospital in connection with surgery.
- under this plan, for prescription drug charges made for a person who is not Confined in a Hospital.
- for which benefits are not payable according to the "General Limitations" section.

GM6000 CM66 COM343V187M

Covered Expenses will not include, and no payment will be made for, expenses incurred:

- for or in connection with procedures to reverse sterilization.

GM6000 CM66 COM440V1

- for or in connection with an Injury or a Sickness which is a Pre-existing Condition, unless those expenses are incurred after a continuous one-year period during which a person is satisfying a waiting period and/or is insured for these benefits.

Pre-Existing Condition

A Pre-existing Condition is an Injury or a Sickness for which a person receives treatment, incurs expenses or receives a diagnosis from a Physician during the 90 days before the earlier of the date a person begins an eligibility waiting period, or becomes insured for these benefits.

Exceptions to Pre-existing Condition Limitation

Pregnancy, and genetic information with no related treatment, will not be considered Pre-existing Conditions.

A newborn child, an adopted child, or a child placed for adoption before age 18 will not be subject to any Pre-existing Condition limitation if such child was covered within 31 days of birth, adoption or placement for adoption. Such waiver will not apply if 63 days elapse between coverage during a prior period of Creditable Coverage and coverage under this plan.

Credit for Coverage Under Prior Plan

If a person was previously covered under a plan which qualifies as Creditable Coverage, the following will apply, provided he notifies the Employer of such prior coverage, and fewer than 63 days elapse between coverage under the prior plan and coverage under this plan, exclusive of any waiting period.

CG will reduce any Pre-existing Condition limitation period under this policy by the number of days of prior Creditable Coverage you had under a creditable health plan or policy.

GM6000 CM10 COM126V402

Certification of Prior Creditable Coverage

You must provide proof of your prior Creditable Coverage in order to reduce a Pre-existing Condition limitation period. You should submit proof of prior coverage with your enrollment material. Certification, or other proofs of coverage which need to be submitted outside the standard enrollment form process for any reason, may be sent directly to: Eligibility Services, CIGNA HealthCare, P.O. Box 9077, Melville, NY 11747-9077. You should contact the plan administrator or CIGNA Customer Service Representative if assistance is needed to obtain proof of prior Creditable Coverage. Once your prior coverage records are reviewed and credit is calculated, you will receive a notice of any remaining Pre-existing Condition limitation period.

Creditable Coverage

Creditable Coverage will include coverage under: a self-insured employer group health plan; individual or group health insurance indemnity or HMO plans; state or federal continuation coverage; individual or group health conversion plans; Part A or Part B of Medicare; Medicaid, except coverage solely for pediatric vaccines; the Indian Health Service; the Peace Corps Act; a state health benefits risk pool; a public health plan; health coverage for current and former members of the armed forces and their Dependents; medical savings accounts; and health insurance for federal employees and their Dependents.

GM6000 CM10 COM126V94

Organ Transplant Travel Benefit

CG will pay, subject to the Organ Transplant Travel Benefit Maximum shown in the Schedule, 100% of the travel expenses incurred by you or your covered Dependent for charges for transportation, lodging and food associated with a preapproved organ transplant. All expenses must be preapproved by your Transplant Case Manager. Expenses in excess of the Maximum shown in the Schedule will not be payable. Organ Transplant Travel Benefits are not available for kidney and autologous bone marrow/stem cell transplants. Benefits for transportation, lodging and food are available to you only if you or your covered Dependent is the recipient of a preapproved organ/tissue transplant from a Lifesource Organ Transplant Network Facility; such benefits are not subject to any individual or family deductible shown in The Schedule. The term recipient is defined to include you or your covered Dependent receiving preapproved transplant related services during any of the following: (a) evaluation, (b) candidacy, (c) transplant event, or (d) post transplant care. Additionally, this benefit is not subject to the Lifetime Maximum Benefit shown in The Schedule.

If you or your Dependent elects to use a Lifesource Organ Transplant Network facility, and treatment at such network facility has been preapproved by CG, travel expenses for the person receiving the transplant will include charges for:

(1) transportation to and from the transplant site (including charges for a rental car used during a period of care at the transplant facility);

(2) lodging while at, or travelling to and from the transplant site; and

(3) food while at, or traveling to and from the transplant site.

Travel expenses will not include any charges for:

(a) transportation, lodging and food associated with an organ transplant performed at a facility other than a Lifesource Organ Transplant Network Facility;

(b) transplant travel benefits costs incurred due to travel within 60 miles of your home;

(c) air travel via air ambulance;

(d) laundry bills;

(e) telephone bills;

(f) alcohol or tobacco products; or

(g) transportation charges which exceed coach class rates.

GM6000 ORG3

The charges associated with the items (1), (2) and (3) will be considered travel expenses for only one companion at any time in addition to the actual transplant recipient. In the case of a minor recipient, these items will be considered for both parents. The term companion includes a spouse, family member, domestic partner, legal guardian of you or your Dependent, or any person not related to you, but actively involved as your caregiver.

Organ Transplant Travel Benefits may be considered to be taxable income by the Internal Revenue Service. Please consult with your Benefit Plan Administrator or Tax Advisor for further information.

GM6000 ORG3

Organ Transplant Travel Benefit

CG will pay, subject to the Organ Transplant Travel Benefit Maximum shown in the Schedule, 100% of the travel expenses incurred by you or your covered Dependent for charges for transportation, lodging and food associated with a preapproved organ transplant. All expenses must be preapproved by your Transplant Case Manager. Organ Transplant Travel Benefits are not available for kidney and autologous bone marrow/stem cell transplants. Benefits for transportation, lodging and food are available to you only if you or your covered Dependent is the recipient of a preapproved organ/tissue transplant from a Lifesource Organ Transplant Network Facility; such benefits are not subject to any individual or family deductible shown in the Schedule. The term recipient is defined to include you or your covered Dependent receiving preapproved transplant related services during any of the following: (a) evaluation, (b) candidacy, (c) transplant event, or (d) post transplant care. Additionally, this benefit is not subject to the Lifetime Maximum Benefit shown in The Schedule.

If you or your Dependent elects to use a Lifesource Organ Transplant Network Facility, and treatment at such network facility has been preapproved by CG, travel expenses for the person receiving the transplant will include charges for:

(1) transportation to and from the transplant site (including charges for a rental car used during a period of care at the transplant facility);

(2) lodging while at, or travelling to and from the transplant site; and

(3) food while at, or traveling to and from the transplant site.

Travel expenses will not include any charges for:

(a) transportation, lodging and food associated with an organ transplant performed at a facility other than a Lifesource Organ Transplant Network Facility;

(b) transplant travel benefits costs incurred due to travel within 60 miles of your home;

(c) air travel via air ambulance;

(d) laundry bills;

(e) telephone bills;

(f) alcohol or tobacco products; or

(g) transportation charges which exceed coach class rates.

GM6000 ORG1

The charges associated with the items (1), (2) and (3) will be considered travel expenses for only one companion at any time in addition to the actual transplant recipient. In the case of a minor recipient, these items will be considered for both parents. The term companion includes a spouse, family member, domestic partner, legal guardian of you or your Dependent, or any person not related to you, but actively involved as your caregiver.

Organ Transplant Travel Benefits may be considered to be taxable income by the Internal Revenue Service. Please consult with your Benefit Plan Administrator or Tax Advisor for further information.

GM6000 ORG2

Medical Conversion Privilege

For You and Your Dependents

When a person's Medical Expense Insurance ceases, he may be eligible to be insured under an individual policy of medical care benefits (called the Converted Policy). A Converted Policy will be issued by CG only to a person who is Entitled to Convert, and only if he applies in writing and pays the first premium for the Converted Policy to CG within 31 days after the date his insurance ceases. Evidence of good health is not needed.

Employees Entitled To Convert

You are Entitled To Convert Medical Expense Insurance for yourself and all of your Dependents who are insured when your insurance ceased, except a Dependent who is eligible for Medicare or would be Overinsured, but only if:

- Your insurance ceased because:
  - you were no longer in Active Service or
  - you were no longer eligible for Medical Expense Insurance.
- You are not eligible for Medicare.
- You would not be Overinsured.

If you retire you may apply for a Converted Policy within 31 days after your retirement date in place of any continuation of your insurance that may be available under this plan when you retire, if you are otherwise Entitled to Convert.

Dependents Entitled To Convert

The following Dependents are also Entitled to Convert:

- a child whose insurance under this plan ceases because he no longer qualifies as a Dependent or because of your death;
- a spouse whose insurance under this plan ceases due to divorce, annulment of marriage or your death;
- your Dependents, if you are not Entitled to Convert solely because you are eligible for Medicare;

but only if that Dependent: (a) was insured when your insurance ceased; (b) is not eligible for Medicare; and (c) would not be Overinsured.

GM6000 CP1 V-8
GM6000 CP2 CON5

Overinsured

A person will be considered Overinsured if either of the following occurs:

- His insurance under this plan is replaced by similar group coverage within 31 days.
- The benefits under the Converted Policy, combined with Similar Benefits, result in an excess of insurance based on CG's underwriting standards for individual policies. Similar Benefits are: (a) those for which the person is covered by another hospital, surgical or medical expense insurance policy, or a hospital, or medical service subscriber contract, or a medical practice or other prepayment plan or by any other plan or program; or (b) those for which the person is eligible, whether or not covered, under any plan of group coverage on an insured or uninsured basis; or (c) those available for the person by or through any state, provincial or federal law.

Converted Policy

The Converted Policy will be one of CG's current offerings at the time the first premium is received based on its rules for Converted Policies. It will comply with the laws of the jurisdiction where the group medical policy is issued. However, if the applicant for the Converted Policy resides elsewhere, the Converted Policy will be on a form which meets the conversion requirements of the jurisdiction where he resides. The Converted Policy offering may include medical benefits on a group basis. The Converted Policy need not provide major medical coverage unless it is required by the laws of the jurisdiction in which the Converted Policy is issued.

GM6000 CP3 V-5
CON26

The Converted Policy will be issued to you if you are Entitled to Convert, insuring you and those Dependents for whom you may convert. If you are not Entitled to Convert and your spouse and children are, it will be issued to the spouse, covering all such Dependents. Otherwise, a Converted Policy will be issued to each Dependent who is Entitled to Convert. The Converted Policy will take effect on the day after the person's insurance under this plan ceases. The premium on its effective date will be based on: (a) class of risk and age; and (b) benefits.

The Converted Policy may not exclude any pre-existing condition not excluded by this plan. During the first 12 months the Converted Policy is in effect, the amount payable under it will be reduced so that the total amount payable under the Converted Policy and the Medical Benefits Extension of this plan will not be more than the amount that would have been payable under this plan if the person's insurance had not ceased. After that, the amount payable under the Converted Policy will be reduced by any amount still payable under the Medical Benefits Extension of this plan.

CG or the Policyholder will give you, on request, further details of the Converted Policy.

GM6000 CP4 CON29

General Limitations

Medical Benefits
No payment will be made for expenses incurred for you or any one of your Dependents:

- for or in connection with the treatment of mental illness, alcoholism or drug abuse under this plan. (Benefits for charges made for the treatment of mental illness, alcoholism and drug abuse may be payable under another plan sponsored by your Employer; see your Plan administrator for details.)
- for or in connection with an Injury arising out of, or in the course of , any employment for wage or profit;
- for or in connection with a Sickness which is covered under any workers' compensation or similar law;
- for charges made by a Hospital owned or operated by or which provides care or performs services for the United States Government, if such charges are directly related to a military-service-connected Sickness or Injury;
- to the extent that payment is unlawful where the person resides when the expenses are incurred;
- for charges which the person is not legally required to pay;
- to the extent that they are more than Reasonable and Customary Charges;
- for charges for unnecessary care, treatment or surgery, except as specified in any certification requirement shown in The Schedule;
- for or in connection with Custodial Services, education or training;
- to the extent that you or any one of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid;
- for experimental drugs or substances not approved by the Food and Drug Administration, or for drugs labeled: "Caution - limited by federal law to investigational use";
- for or in connection with experimental procedures or treatment methods not approved by the American Medical Association or the appropriate medical specialty society;

GM6000 GEN18V2M DG

- to the extent of the exclusions imposed by any certification requirement shown in The Schedule;
- for charges made by a Physician for or in connection with surgery which exceed the following maximum when two or more surgical procedures are performed at one time: the maximum amount payable will be the amount otherwise payable for the most expensive procedure, and 1/2 of the amount otherwise payable for all other surgical procedures;
- for or in connection with in vitro fertilization or similar procedures.

GM6000 GEN246V4 DG

- for charges made by an assistant surgeon in excess of 20 percent of the surgeon's allowable charge; or for charges made by a cosurgeon in excess of the surgeon's allowable charge plus 20 percent (for purposes of this limitation, allowable charge means the amount payable to the surgeon prior to any reductions due to coinsurance or deductible amounts);
- for charges made for or in connection with the purchase or replacement of contact lenses; except, the purchase of the first pair of contact lenses that follows cataract surgery will be covered;
- for charges made for or in connection with routine refractions , eye exercises and for surgical treatment for the correction of a refractive error, including radial keratotomy, when eyeglasses or contact lenses may be worn;
- for charges for supplies, care, treatment or surgery which are not considered essential for the necessary care and treatment of an Injury or Sickness, as determined by CG;
- for charges made for or in connection with tired, weak or strained feet for which treatment consists of routine foot care, including but not limited to, the removal of calluses and corns or the trimming of nails medically necessary;
- for or in connection with speech therapy, if such therapy is: (a) used to improve speech skills that have not fully developed; (b) can be considered custodial or educational; or (c) is intended to maintain speech communication; speech therapy which is not restorative in nature will not be covered;
- for charges made by any covered provider who is a member of your family or your Dependent's family.

GM6000 GL9 GEN253V3 DG

No payment will be made for expenses incurred for you or any one of your Dependents to the extent that benefits are paid or payable for those expenses under the mandatory part of any auto insurance policy written to comply with:

- a "no-fault" insurance law; or
- an uninsured motorist insurance law.

CG will take into account any adjustment option chosen under such part by you or any one of your Dependents.

GM6000 GEN151

Medicare Eligibles

The Medical Insurance for a person who is age 65 or older and eligible for Medicare will be modified as follows:

- If expenses are incurred for which benefits are payable under both this plan and Part A of Medicare, benefits will be payable under this plan only for those expenses so incurred which exceed the amount payable under Part A of Medicare.
- The amount payable under this plan for expenses incurred for which benefits are payable under both this plan and Part B of Medicare will be reduced by the amount payable for those expenses under Part B of Medicare.
- The Comprehensive Medical Deductible will apply only to Covered Expenses incurred for prescription drugs and charges made by a Nurse.

For a person who is less than age 65 and eligible for Medicare, the amount payable under this plan will be reduced so that the total amount payable by CG and Medicare will be no more than 100% of the expenses incurred.

The provisions above will not apply to a person while Medicare, based on the rules established by the Social Security Act of 1965 as amended, is assuming the role of secondary payer to this plan for that person.

GM6000 ME1 V-5
MEL3

CG will assume the amount payable under:

- Part A of Medicare for a person who is eligible for that Part without premium payment, but has not applied, to be the amount he would receive if he had applied.
- Part B of Medicare for a person who is entitled to be enrolled in that Part, but is not, to be the amount he would receive if he were enrolled.
- Part B of Medicare for a person who has entered into a private contract with a provider, to be the amount he would receive in the absence of such private contract.

A person is considered eligible for Medicare on the earliest date any coverage under Medicare could become effective for him.

GM6000 ME1 MEL1V1

Coordination of Benefits

If you or any one of your Dependents is covered under more than one Plan, benefits payable from all such Plans will be coordinated.

Coordination of Benefits will be used to determine the benefits payable for a person for any Claim Determination Period if, for the Allowable Expenses incurred in that Period, the sum of:

(a) the benefits that would be payable from this Plan in the absence of coordination; and

(b) the benefits that would be payable from all other Plans without Coordination of Benefits provisions in those Plans;

would exceed such Allowable Expenses.

The benefits that would be payable from this Plan for Allowable Expenses incurred in any Claim Determination Period in the absence of Coordination of Benefits will be reduced to the extent required so that the sum of:

(a) those reduced benefits; and

(b) all the benefits payable for those Allowable Expenses from all other Plans;

will not exceed the total of such Allowable Expenses. Benefits payable from all other Plans include the benefits that would have been payable had proper claim been made for them.

However, the benefits of another Plan will be ignored when the benefits of this Plan are determined if: (a) the Benefit Determination Rules would require this Plan to determine its benefits before that Plan; and (b) the other Plan has a provision that coordinates its benefits with those of this Plan and would, based on its rules, determine its benefits after this Plan.

If however, the insured is a member of a prepaid dental plan and is also an insured under an indemnity dental plan, the indemnity plan will be primary. The indemnity dental plan's

payment will never exceed the member's obligation under the prepaid dental plan.

GM6000 COR63

CG reserves the right to release to or obtain from any other Insurance Company or other organization or person any information which, in its opinion, it needs for the purpose of Coordination of Benefits.

When payments which should have been made under this Plan based on the terms of this section have been made under any other Plans, CG will have the right to pay to any organizations making these payments the amount it determines to be warranted. Amounts paid in this manner will be considered to be benefits paid under this Plan. CG will be released from all liability under this Plan to the extent of these payments. When an overpayment has been made by CG at any time, it will have the right to recover that payment, to the extent of the excess, from the person to whom it was made or any other Insurance Company or organization, as it may determine.

Plan

Plan means any of the following which provides medical or dental benefits or services: (a) group, blanket or franchise insurance coverage; (b) service plan contracts, group or individual practice or other prepayment plans; or (c) coverage under any: labor-management trusteed plans; union welfare plans; employer organization plans; or employee benefit organization plans. Plan does not include coverage under individual policies or contracts. Each Plan or part of a Plan which has the right to coordinate benefits will be considered a separate Plan.

Allowable Expense

Allowable Expense means any necessary, reasonable and customary item of expense, at least a part of which is covered by any one of the Plans that covers the person for whom claim is made. When the benefits from a Plan are in the form of services, not cash payments, the reasonable cash value of each service is both an Allowable Expense and a benefit paid. Allowable Expense will not include the difference between: (a) the cost of a private room; and (b) the cost of a semiprivate room; except while the person's stay in a private room is medically necessary in terms of generally accepted medical practice.

Claim Determination Period

Claim Determination Period means a calendar year or that part of a calendar year in which the person has been covered under this Plan.

GM6000 CB9
GM6000 CB10 (1) COR23

The rules below establish the order in which benefits will be determined:

(1) The benefits of a Plan which covers the person for whom claim is made other than as a dependent will be determined before a Plan which covers that person as a dependent.

(2) The benefits of a Plan which covers the person for whom claim is made as a dependent of a person whose day of birth occurs first in a calendar year will be determined before a Plan which covers that person as a dependent of a person whose day of birth occurs later in that year; except that: (a) if the other Plan does not have this rule, its alternate rule will govern; and (b) in the case of a dependent child of divorced or separated parents, the rules in item (3) will apply.

(3) If there is a court decree which establishes financial responsibility for medical, dental or other health care of the child, the benefits of the Plan which covers the child as a dependent of the parent so responsible will be determined before any other plan; otherwise:

   (a) The benefits of a Plan which covers the child as a dependent of the parent with custody will be determined before a Plan which covers the child as a dependent of a stepparent or a parent without custody.

   (b) The benefits of a Plan which covers the child as a dependent of a stepparent will be determined before a plan which covers the child as a dependent of the parent without custody.

GM6000 CB10 (2) COR33

(4) When the above rules do not establish the order, the benefits of a plan which has covered the person for whom claim is made for the longer period of time will be determined before a Plan which has covered the person for the shorter period of time; except that:

   (a) The benefits of a Plan which covers the person as a laid-off or retired employee, or his dependent will be determined after a Plan which covers the person as an employee, other than a laid-off or retired employee, or his dependent.

   (b) If the other Plan does not have the rule in item (4)(a), which results in each Plan determining its benefits after the other, then item (4)(a) will not apply.

GM6000 CB11 COR35

Payment of Benefits

To Whom Payable

All Medical Benefits are payable to you. However, at the option of CG and with the consent of the Policyholder, all or any part of them may be paid directly to the person or institution on whose charge claim is based.

If any person to whom benefits are payable is a minor or, in the opinion of CG, is not able to give a valid receipt for any payment due him, such payment will be made to his legal guardian. If no request for payment has been made by his legal guardian, CG may, at its option, make payment to the person or institution appearing to have assumed his custody and support.

If you die while any of these benefits remain unpaid, CG may choose to make direct payment to any of your following living relatives: spouse, mother, father, child or children, brothers or sisters; or to the executors or administrators of your estate.

Payment as described above will release CG from all liability to the extent of any payment made.

Time of Payment

Benefits will be paid by CG when it receives due proof of loss.

Recovery of Overpayment

When an overpayment has been made by CG, CG will have the right at any time to: (a) recover that overpayment from the person to whom or on whose behalf it was made; or (b) offset the amount of that overpayment from a future claim payment.

GM6000 POB12 PMT135V9

Termination of Insurance

Termination of Insurance - Employees

Your insurance will cease on the earliest date below:

- the date you cease to be in a Class of Eligible Employees or cease to qualify for the insurance.
- the last day for which you have made any required contribution for the insurance.
- the date the policy is cancelled.
- the last day of the pay period in which your Active Service ends except as described below.

Any continuation of insurance must be based on a plan which precludes individual selection.

Temporary Layoff or Leave of Absence

If your Active Service ends due to temporary layoff or leave of absence, your insurance will be continued until the date your Employer: (a) stops paying premium for you; or (b) otherwise cancels your insurance. However, your insurance will not be continued for more than 60 days past the date your Active Service ends.

Injury or Sickness

If your Active Service ends due to an Injury or Sickness, your insurance will be continued while you remain totally and continuously disabled as a result of the Injury or Sickness. However, the insurance will not continue past the date your Employer stops paying premium for you or otherwise cancels the insurance.

Retirement (for Medical Insurance)

If your Active Service ends because you retire, your insurance will be continued until the date on which your Employer stops paying premium for you or otherwise cancels the insurance.

GM6000 TER1 TRM15M

Termination of Insurance - Dependents

Your insurance for all of your Dependents will cease on the earliest date below:

- the date your insurance ceases.
- the date you cease to be eligible for Dependent Insurance.
- the last day for which you have made any required contribution for the insurance.
- the date Dependent Insurance is canceled.

Benefits for a Dependent child or student will continue until the last day of the calendar month in which the limiting age is reached.

GM6000 TRM62M

Termination of Insurance - Continuation

Reinstatement of Insurance (except Life Insurance)

If your Insurance ceases because you are called to active duty from status as a reservist on or after August 22, 1990, the insurance for you and your Dependents, including those born during your time of active duty, will be reinstated after your deactivation, provided you apply for reinstatement within 90 days of discharge or within one year of continuous hospitalization from the date of discharge.

Such reinstatement will be without the application of: a) a new waiting period, or b) a new Pre-existing Condition Limitation. A new Pre-existing Condition Limitation will not be applied to a condition that you or your Dependent may have developed while coverage was interrupted. However, no payment will be made for a condition that was the direct result of active military duty.

GM6000 TER1 TRM186V3

Continuation Required by Federal Law For You and Your Dependents

The Continuation Required by Federal Law does not apply to any benefits for loss of life, dismemberment or loss of income.

Federal law enables you or your Dependent to continue health insurance if coverage would cease due to a reduction of your work hours or your termination of employment (other than for gross misconduct). Federal law also enables your Dependents to continue health insurance if their coverage ceases due to your death, divorce or legal separation, or with respect to a Dependent child, failure to continue to qualify as a Dependent. Continuation must be elected in accordance with the rules of your Employer's group health plan(s) and is subject to federal law, regulations and interpretations.

A. Employees and Dependents Continuation Provision

If you and your Dependent's insurance would otherwise cease because of a reduction in the number of hours you work or your termination of employment for any reason other than gross misconduct, you or your Dependent may continue health insurance upon payment of the required premium to the Employer. You and your Dependents must elect to continue insurance within 60 days from the later of: (a) the date of a reduction of your work hours or your termination of employment; (b) the date notice of the right to continue insurance is sent; or (c) the date the insurance would otherwise cease. You must pay the first premium within 45 days from the date you elect to continue coverage. Such insurance will not be continued by CG for you and/or your Dependents, as applicable, beyond the earliest of the following dates:

- 18 months from the date your work hours are reduced or your employment terminates, whichever may occur first;
- the date the policy cancels;
- the date coverage ends due to your failure to pay the required subsequent premium within 30 days of the due date;
- the date your Dependent ceases to qualify as an eligible Dependent;
- after you elect to continue this insurance, the date you first become entitled to Medicare, and for your Dependent, the date he first becomes entitled to Medicare;
- after you elect to continue this insurance, for you, the date you first become covered under another group health plan, unless you have a condition for which the new plan limits or excludes coverage, in which case coverage will continue until the earliest of any other point above.

COBRA13

B. Dependent Continuation Provision

If health insurance for your Dependents would otherwise cease because of:

(1) your death;

(2) divorce or legal separation; or

(3) with respect to a Dependent child, failure to continue to qualify as a Dependent,

such insurance may be continued upon payment of the required premium to the Employer. In the case of (2) or (3) above, you or your Dependent must notify your Employer within 60 days of such event. In addition, a Dependent must elect to continue insurance within 60 days from the later of: (a) the date the insurance would otherwise cease; or (b) the date notice of the right to continue insurance is sent.

CG will not continue the health insurance of a Dependent beyond the earliest of the following dates:

- 36 months from the date of (1), (2) or (3) above, whichever may occur first;
- the date coverage ends due to failure to pay the required subsequent premium within 30 days of the due date;
- after the Dependent elects to continue this insurance, the date the Dependent first becomes entitled to Medicare;
- the date the policy cancels; or
- after the Dependent elects to continue this insurance, the date the Dependent first becomes covered under another group health plan, unless the Dependent has a condition for which the new plan limits or excludes coverage, in which case coverage will continue until the earliest of any other point above.

C. Subsequent Events Affecting Dependent Coverage

If, within the initial 18-month continuation period, your Dependent would lose coverage because of an event described in (1), (2), or (3) of Section B, or because of your coverage loss due to your subsequent entitlement to Medicare, after you have continued your Dependent's coverage due to your employment termination or reduction in work hours, your

Dependent may continue coverage for up to 36 months from the date of loss of employment or reduction in work hours.

COBRA14

If your employment ends or your work hours are reduced within 18 months after your entitlement to Medicare, your covered Dependent may continue coverage for up to 36 months from the date you become entitled to Medicare.

If your employment ends or your work hours are reduced more than 18 months after your entitlement to Medicare, your covered Dependent may continue coverage for up to 18 months from the date your employment ends or your work hours are reduced.

Disabled Individuals Continuation Provisions

If you or your Dependent is disabled before or within the first 60 days of continuation of coverage which follow termination of employment or a reduction in work hours, the disabled person may continue health insurance for up to an additional 11 months beyond the 18-month period.

If you or your Dependents who are not disabled elect to continue coverage, such family members of the disabled person may extend coverage for up to an additional 11 months, if they otherwise remain eligible, and notice of disability is provided as described in (b), below.

To be eligible you or your Dependent must:

(a) be declared disabled as of a day before or during the first 60 days of continuation, under Title II or XVI by the Social Security Administration; and

(b) notify the plan administrator of the Social Security Administration's determination within 60 days following the determination and within the initial 18-month continuation period, and provide the Plan Administrator with a copy of the determination.

Termination of coverage for all covered persons during the additional 11 months will occur if the disabled person is found by the Social Security Administration to be no longer disabled. Termination for this reason will occur on the first day of the month beginning more than 30 days after the date of the final determination.

All reasons for termination described in sections A and B which apply to the initial 18 months will also apply to any or all covered persons for any additional months of coverage.

COBRA4

D. Effect of Employer Chapter 11 Proceedings on Retiree Coverage

If you are covered as a retiree, and a proceeding under USC Chapter 11, bankruptcy for the Employer results in a substantial loss of coverage for you or your Dependents within one year before or after such proceeding, coverage will continue until: (a) for you, your death; and (b) for your Dependent surviving spouse or Dependent child, up to 36 months from your death.

COBRA15

E. Payment of Premium

This Plan may require the payment of an amount that does not exceed 102% of the applicable premium, except this Plan may require payment of up to 150% of the Applicable Premium for any extended period of continuation coverage for a covered person who is disabled. The additional 48% may only be applied to the premium for the rating category that includes the disabled individual, and only for the additional 11 months.

Applicable Premium is determined as follows:

1. if the Employee alone elects to continue coverage, the Employee will be charged the active Employee rate;
2. if a Dependent spouse alone elects to continue coverage, the spouse will be charged the active Employee rate;
3. if a Dependent child or children elect to continue coverage without a parent also electing the continuation, each child will be charged the active Employee rate;
4. if the entire family elects to continue coverage, they will be charged the family rate;
5. if the Schedule of Premium rates is set up on a step-rate basis, the active rate basis that fits the individuals who elect to continue their coverage is the rate that will be charged. If only children elect to continue coverage, each child will be charged the Employee Only rate.

Timely Payment

If Payment is made within the grace period in an amount not significantly less than the amount the Plan requires to be paid, the amount must be deemed to satisfy the Plan's requirement. However, you must be notified and allowed at least 30 days after notice is provided for payment to be made.

F. Providing Notification of Your Status to Health Care Providers During the Grace Period

If, after you elect to continue coverage, a health care provider contacts this Plan to confirm coverage for a period for which premium has not yet been received, the Plan must give a complete and accurate response.

COBRA17

G. Notification Requirements

Your Employer should send you initial notification of coverage continuation rights as required by federal law; (a) when the Plan first becomes subject to federal continuation

requirements; (b) when you are hired; and (c) when you add a spouse as a Dependent for benefits under the Plan. Receipt of this certificate may serve as such notice.

If you become eligible to continue coverage per federal law, your Employer must send you notification within 14 days. If the Plan has a Plan Administrator, the Employer must notify the Plan Administrator within 30 days. The Plan Administrator must notify you within 14 days, thereafter.

If eligibility to continue coverage is due to divorce, legal separation or a Dependent child losing eligibility for coverage under the Plan, you or your Dependent spouse must notify your Employer within 60 days of such event. Your Employer must notify you of the right to continue coverage within 14 days after receipt of notification of such event.

COBRA18

Conversion Available Following Continuation

If you or your Dependent's Continuation ends due to the expiration of the maximum 18-, 29- or 36-month continuation period, whichever applies, you or your Dependent may be entitled to convert to the insurance in accordance with the Medical Conversion benefit then available to Employees and their Dependents.

Interaction With Other Continuation Benefits

A person who is eligible to continue insurance under both (1) and (2) below may continue the insurance, upon payment of any required premium, for a period of time not to exceed the longer of: (1) the continuation required by federal law; or (2) any other continuation of insurance provided in this Certificate.

Newly Acquired Dependents

If, while your insurance is being continued under the continuation required by federal law provisions, you acquire a new Dependent, such Dependent will be eligible for this Continuation provided:

- the required premium is paid; and
- CG is notified of your newly acquired Dependent in accordance with the terms of the policy.

If events (1) or (2) of Section B should subsequently occur for your newly acquired Dependent spouse, such spouse will not be entitled to continue his insurance. However, your Dependent child will be able to continue his insurance.

If events described in Section C should subsequently occur for your child who is born, adopted or placed for adoption as a newly acquired Dependent, coverage will be continued according to that section.

COBRA5

Requirements of Family and Medical Leave Act of 1993

Any provisions of the policy that provide for: (a) continuation of insurance during a leave of absence; and (b) reinstatement of insurance following a return to Active Service; are modified by the following provisions of the federal Family and Medical Leave Act of 1993, where applicable:

A. Continuation of Health Insurance During Leave

Your health insurance will be continued during a leave of absence if:

- that leave qualifies as a leave of absence under the Family and Medical Leave Act of 1993; and
- you are an eligible Employee under the terms of that Act.

The cost of your health insurance during such leave must be paid, whether entirely by your Employer or in part by you and your Employer.

B. Reinstatement of Canceled Insurance Following Leave

Upon your return to Active Service following a leave of absence that qualifies under the Family and Medical Leave Act of 1993, any canceled insurance (health, life or disability) will be reinstated as of the date of your return.

You will not be required to satisfy any eligibility or benefit waiting period or the requirements of any Pre-existing Condition Limitation to the extent that they had been satisfied prior to the start of such leave of absence.

Your Employer will give you detailed information about the Family and Medical Leave Act of 1993.

GM6000 TER5 TRM191V1

Benefits Extension

Medical Benefits Extension

Any expense incurred within one year after a person's Comprehensive Medical Benefits cease will be deemed to be incurred while he is insured if such expense is for an Injury or Sickness which causes him to be Totally Disabled from the day his insurance ceases until that expense is incurred.

The terms of this Medical Benefits Extension will not apply to: (a) a child born as a result of a pregnancy which exists when a person's benefits cease; or (b) any person when he becomes insured under another group policy for medical benefits.

Totally Disabled

You will be considered Totally Disabled if, because of an Injury or a Sickness:

- you are unable to perform the basic duties of your occupation; and
- you are not performing any other work or engaging in any other occupation for wage or profit.

Your Dependent will be considered Totally Disabled if, because of an Injury or a Sickness:

- he is unable to engage in the normal activities of a person of the same age, sex and ability; or
- in the case of a Dependent who normally works for wage or profit, he is not performing such work.

GM6000 BE 3 BEX85

THE FOLLOWING WILL APPLY TO RESIDENTS OF ARIZONA

When You Have a Complaint or an Appeal

For the purposes of this section, any reference to "you," "your" or "Member" also refers to a representative or provider designated by you to act on your behalf, unless otherwise noted.

We want you to be completely satisfied with the care you receive. That is why we have established a process for addressing your concerns and solving your problems. The following describes the process by which Members may obtain information and submit concerns regarding service, benefits, and coverage. For more information, see the Benefit Inquiry and Appeals Information Packet ("Appeal Packet"). Upon membership renewal or at any time thereafter, you may request an additional Appeal Packet by contacting Member Services at the toll-free number that appears on your Benefit Identification Card.

Start with Member Services

We are here to listen and help. If you have a concern regarding a person, a service, the quality of care, or contractual benefits, you can call our toll-free number and explain your concern to one of our Customer Service representatives. You can also express that concern in writing. Please call or write to us at the following:

> Customer Services Toll-Free Number or address that appears on your Benefit Identification card, explanation of benefits or claim form.

We will do our best to resolve the matter on your initial contact. If we need more time to review or investigate your concern, we will get back to you as soon as possible, but in any case within 30 days.

If you are not satisfied with the results of a coverage decision, you can start the appeals procedure.

Appeals Procedure

CG has a two step appeals procedure for coverage decisions. To initiate an appeal, you must submit a request for an appeal in writing within two years of receipt of a denial notice. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask to register your appeal by telephone. Call or write to us at the toll-free number or address on your Benefit Identification card, explanation of benefits or claim form.

GM6000 APL590 V1

Level One Appeal

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by a health care professional.

Within five working days after receiving your request for review, CG will mail you and your Primary Care Physician ("PCP") or treating Provider a notice indicating that your request was received, and a copy of the Appeal Packet (sent to PCP or treating Provider upon request). For level one appeals, we will respond in writing with a decision within 15 calendar days after we receive an appeal for a required preservice or concurrent care coverage determination (decision). We will respond within 30 calendar days after we receive an appeal for a postservice coverage determination. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

You may request that the appeal process be expedited if, your PCP or treating Physician certifies in writing and provides supporting documentation that the time frames under this process are likely to cause a significant negative change in your medical condition which cannot be managed without the requested services; or your appeal involves nonauthorization of an admission or continuing inpatient Hospital stay. When an appeal is expedited, we will respond orally and in writing with a decision within the lesser of one working day or 72 hours.

GM6000 APL591

Level Two Appeal

If you are dissatisfied with our level one appeal decision, you may request a second review. To start a level two appeal, follow the same process required for a level one appeal. Please send your review request relating to denial of a requested service that has not already been provided within 365 days of the last denial. Your review requests relating to payment of a service already provided should be sent within two years of

the last denial. To help us make a decision on your appeal, you or your provider should also send us any more information (that you haven't already sent us) to show why we should authorize the requested service or pay the claim.

Most requests for a second review will be conducted by the Appeals Committee, which consists of at least three people. Anyone involved in the prior decision may not vote on the Committee. For appeals involving Medical Necessity or clinical appropriateness, the Committee will consult with at least one Physician reviewer in the same or similar specialty as the care under consideration, as determined by CG's Physician reviewer. You may present your situation to the Committee in person or by conference call.

For level two appeals we will acknowledge in writing that we have received your request within five working days after receiving your request and schedule a Committee review. For required preservice and concurrent care coverage determinations, the Committee review will be completed within 15 calendar days. For postservice claims, the Committee review and written notification of the Appeal Committee's decision will be completed within 30 calendar days. If more time or information is needed to make the preservice or concurrent care determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the Committee to complete the review.

You may request that the appeal process be expedited if, your Primary Care Physician or treating Physician certifies in writing and provides supporting documentation that the time frames under this process are likely to cause a significant negative change in your medical condition which cannot be managed without the requested services, or your appeal involves nonauthorization of an admission or continuing inpatient Hospital stay. When an appeal is expedited, we will respond orally with a decision within 72 hours, followed up in writing.

At any time during the appeal process CG has the option to send your appeal directly to External Independent Review without making a decision during the appeal process.

GM6000 APL592 V1

External Independent Review

1. Eligibility

   Under Arizona law, a Member may seek an Expedited or Standard External Independent Review only after seeking any available Expedited Review, Level One Appeal, and Level Two Appeal. Your request for an Expedited or Standard External Independent Review should be submitted in writing.

2. Deadlines Applicable to the Standard External Independent Review Process

   After receiving written notice from CG that your Level Two Appeal has been denied, you have 30 calendar days to submit a written request to CG for External Independent Review. Your request must include any material justification or documentation to support your request for the service or payment of a claim.

   a. Medical Necessity Issues

      These are cases where we have decided not to authorize a service because we think the services you (or your treating provider) are asking for, are not medically necessary to treat your problem. For medical necessity cases, the independent reviewer is a provider retained by an outside independent review organization ("IRO"), that is procured by the Arizona Insurance Department, and not connected with our company. The IRO provider must be a provider who typically manages the condition under review. If your appeal for External Independent Review involves an issue of medical necessity:

      (1) Within five working days of receipt of your request for External Independent Review, CG will:

      - mail a written notice to you, your PCP or treating provider, and the Director of the Arizona Department of Insurance ("Director of Insurance") of your request for External Independent Review, and
      - Send the Director of Insurance: the request for review; your policy, evidence of coverage or similar document; all medical records and supporting documentation used to render our decision; a summary of the applicable issues including a statement of our decision; the criteria used and clinical reasons for our decision; and the relevant portions of our utilization review guidelines. We must also include the name and credentials of the health care provider who reviewed and upheld the denial at the earlier appeal levels.

GM6000 APL593

      (2) Within five days of receiving our information, the Insurance Director must send all submitted information to an external independent review organization (the "IRO").

      (3) Within 21 days of receiving the information the IRO must make a decision and send the decision to the Insurance Director.

      (4) Within five working days of receiving the IRO's decision, The Insurance Director must mail a notice of the decision to us, you, and your

treating provider. If the IRO decides that CG should provide the service or pay the claim, CG must then authorize the service or pay the claim. If the IRO agrees with CG's decision to deny the service or payment, the appeal is over. Your only further option is to pursue your claim in Superior Court.

b. Coverage Issues

These are cases where we have denied coverage because we believe the requested service is not covered under your certificate of coverage. For contract coverage cases, the Arizona Insurance Department is the independent reviewer. If your appeal for External Independent Review involves an issue of service of benefits coverage or a denied claim:

(1) Within five working days of receipt of your request for External Independent Review, CG will:

- mail a written notice to you, your PCP or treating provider, and the Director of Insurance of your request for External Independent Review, and
- send the Director of Insurance: your request for review; your policy, evidence of coverage or similar document; all medical records and supporting documentation used to render our decision; a summary of the applicable issues including a statement of our decision; the criteria used and any clinical reasons for our decision; and the relevant portions of our utilization review guidelines.

(2) Within 15 working days of the Director's receipt of your request for External Independent Review from CG, the Director of Insurance will:

- determine whether the service or claim is covered, and
- mail the decision to CG. If the Director decides that we should provide the service or pay the claim, we must do so.

(3) If the Director of Insurance is unable to determine an issue of coverage, the Director will forward your case to an IRO. The IRO will have 21 days to make a decision and send it to the Insurance Director. The Insurance Director will have five working days after receiving the IRO's decision to send the decision to us, you, and your treating provider.

(4) CG will provide any covered service or pay any covered claim determined to be medically necessary by the independent reviewer(s) and provide any service or pay any claim determined to be covered by the Director of Insurance regardless of whether CG elects to seek judicial review of the decision made through the External Independent Review Process.

(5) If you disagree with the Insurance Director's final decision on a contract coverage issue, you may request a hearing with the Office of Administrative Hearings ("OAH"). If CG disagrees with the Insurance Director's final decision, CG may also request a hearing before the OAH. A hearing must be requested within 30 calendar days of receiving the Insurance Director's decision.

3. Deadlines Applicable to the Expedited External Independent Review Process

After receiving written notice from CG that your Expedited Level Two Appeal has been denied, you have only five business days to submit a written request to CG for an Expedited External Independent Review. Your request must include any material justification or documentation to support your request for the service or payment of a claim.

a. Medical Necessity Issues

If your appeal for Expedited External Independent Review involves an issue of medical necessity:

(1) Within one working day of receipt of your request for an Expedited External Independent Review, CG will:

- mail a written acknowledgment to you, your PCP or treating provider, and the Director of your request for Expedited External Independent Review, and

- forward to the Director your request for Expedited External Independent Review, the terms of the agreement in your contract, all medical records and supporting documentation used to render the adverse decision, a summary description of the applicable issues including a statement of CG's decision, the criteria used and the clinical reasons for the decision, relevant portions of CG's utilization review plan and the name and the credentials of the licensed health care provider who reviewed the case.

(2) Within two working days after the Director receives the information outlined above, the Director will choose an independent review

organization (IRO) and forward to the organization all of the information received by the Director.

(3) Within five working days of receiving a case for Expedited External Independent Review from the Director, the IRO will evaluate and analyze the case and based on all the information received, render a decision and send the decision to the Director. Within one working day after receiving a notice of the decision from the IRO, the Director will mail a notice of the decision to you, your PCP or treating provider, and CG.

b. Coverage Issues

If your appeal for Expedited External Independent Review involves a contract coverage issue:

(1) Within one working day of receipt of your request for an Expedited External Independent Review, CG will:

- mail a written acknowledgment to you, your PCP or treating provider, and the Director of your request for Expedited External Independent Review, and

GM6000 APL629

- forward to the Director your request for an Expedited External Independent Review, the terms of the agreement in your contract, all medical records and supporting documentation used to render the adverse decision, a summary description of the applicable issues including a statement of CG's decision, the criteria used and the clinical reasons for the decision, relevant portions of CG's utilization review plan and the name and the credentials of the licensed health care provider who reviewed the case.

(2) Within two working days after receipt of all the information outlined above, the Director will determine if the service or claim is covered and mail a notice of the determination to you, your PCP or treating provider, and CG.

(3) If the Director of Insurance is unable to determine an issue of coverage, the Director will forward your case to an IRO. The IRO will have five working days to make a decision and send it to the Director. The Director will have one working day after receiving the IRO's decision to send the decision to CG, you and your treating provider.

(4) CG will provide any covered service or pay any covered claim determined to be medically necessary by the independent reviewer(s) and provide any service or pay any claim determined to be covered by the Director regardless of whether CG elects to seek judicial review of the decision made through the External Independent Review Process.

(5) If you disagree with the Insurance Director's final decision on a contract coverage issue, you may request a hearing with the Office of Administrative Hearings ("OAH"). If CG disagrees with the Director's final decision, CG may also request a hearing before OAH. A hearing must be requested within 30 days of receiving the Director's decision.

The Independent Review Program is a voluntary program arranged by CG.

GM6000 APL630

Under Arizona law, if you intend to file suit regarding a denial of benefit claim or services you believe are medically necessary, you are required to provide written notice to CG at least 30 days before filing the suit stating your intention to file suit and the basis of your suit. You must include in your notice the following:

Member Name
Member Identification Number
Member Date of Birth
Basis of Suit (reasons, facts, date(s) of treatment or request)

Notice will be considered provided by you on the date received by CG. The notice of intent to file suit must be sent to CG via Certified Mail Return Receipt Request to the following address:

Attention: HealthCare Litigation Unit W-26
Notice of Intent to File Suit
Connecticut General Life Insurance Company
900 Cottage Grove Road
Hartford, CT 06152

Receipt of Documents

Any written notice, acknowledgment, request, decision or other written documents required to be mailed during the process is deemed received by the person to whom the document is properly addressed on the fifth working day after being mailed. "Properly addressed" means your last known address.

Complaints to the Arizona Department of Insurance

The Director of the Arizona Department of Insurance is required by law to require any Member who files a complaint with the Arizona Department of Insurance relating to an adverse decision to first pursue the review process established by the Arizona Legislature and CG as described above.

GM6000 APL631

Notice of Benefit Determination on Appeal

Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific plan provisions on which the determination is based; (3) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined; (4) a statement describing any voluntary appeal procedures offered by the plan and the claimant's right to bring an action under ERISA section 502(a); (5) upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit.

You also have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the decision on review. You or your plan may have other voluntary alternative dispute resolution options such as Mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your State insurance regulatory agency. You may also contact the Plan Administrator.

Relevant Information

Relevant Information is any document, record, or other information which (a) was relied upon in making the benefit determination; (b) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; (c) demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or (d) constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit or the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

Legal Action

If your plan is governed by ERISA, you have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the outcome of the Appeals Procedure. In most instances, you may not initiate a legal action against CG until you have completed the Level One and Level Two Appeal processes. If your Appeal is expedited, there is no need to complete the Level Two process prior to bringing legal action.

GM6000 APL596

Definitions

Active Service

You will be considered in Active Service:

- on any of your Employer's scheduled work days if you are performing the regular duties of your work on a full-time basis on that day either at your Employer's place of business or at some location to which you are required to travel for your Employer's business;
- on a day which is not one of your Employer's scheduled work days if you were in Active Service on the preceding scheduled work day.

DFS1

Alternative Medicine

The term Alternative Medicine means:

- services, treatments or products not performed, practiced or provided within the practice of standard medicine.

Bed and Board

The term Bed and Board includes all charges made by a Hospital on its own behalf for room and meals and for all general services and activities needed for the care of registered bed patients.

DFS14

Charges

The term "charges" means the actual billed charges; except when the provider has contracted directly or indirectly with CG for a different amount.

DFS940

Coinsurance

The term Coinsurance means the percentage of charges for Covered Expenses that an insured person is required to pay under the Plan.

DFS17

Custodial Services

The term Custodial Services means any services which are not intended primarily to treat a specific Injury or Sickness (including mental illness, alcohol or drug abuse). Custodial Services include, but shall not be limited to:

- services related to watching or protecting a person;
- services related to performing or assisting a person in performing any activities of daily living, such as: (a) walking; (b) grooming; (c) bathing; (d) dressing; (e) getting in or out of bed; (f) toileting; (g) eating; (h) preparing foods; or (i) taking medications that can usually be self-administered; and
- services not required to be performed by trained or skilled medical or paramedical personnel.

DFS537

Dependent

Dependents are:

- your lawful spouse; and
- any unmarried child of yours who is
  - less than 19 years old;
- 19 years but less than 25 years old, enrolled in school as a full-time student and primarily supported by you;
- 19 or more years old and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical handicap. Proof of the child's condition and dependence must be submitted to CG within 31 days after the date the child ceases to qualify above. During the next two years CG may, from time to time, require proof of the continuation of such condition and dependence. After that, CG may require proof no more than once a year;
- children on a church mission.

A child includes a legally adopted child, including that child from the first day of placement by a licensed child placement agency or by the birth parent. It also includes a stepchild who lives with you.

Benefits for a Dependent child or student will continue until the last day of the calendar month in which the limiting age is reached.

Anyone who is eligible as an Employee will not be considered as a Dependent.

No one may be considered as a Dependent of more than one Employee.

DFS1080 DG

Designated Alternative Medicine Center

The term Designated Alternative Medicine Center means:

- a facility or Physician qualified to provide certain Alternative Medicine Services who is designated by the health plan medical director to provide those services.

Durable Medical Equipment

The term Durable Medical Equipment means equipment which:

- can withstand repeated use;
- is primarily and customarily used to serve a medical purpose;
- is generally not useful to a person in the absence of Sickness or Injury; and
- is appropriate for use in the home.

DFS530

Emergency Services/Emergency Medical Condition

Emergency Services are a health care item or service furnished or required to evaluate and treat an Emergency Medical Condition, which may include, but shall not be limited to health care services that are provided in a licensed Hospital's emergency facility by an appropriate provider. An Emergency Medical Condition is the sudden and, at the time, unexpected onset of a health condition that manifests itself by symptoms of sufficient severity that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that immediate medical care is required, which may include, but shall not be limited to:

(1) Placing the person's health in significant jeopardy;

(2) Serious impairment to a bodily function;

(3) Serious dysfunction of any bodily organ or part;

(4) Inadequately controlled pain; or

(5) With respect to a pregnant woman who is having contractions:

  (a) That there is inadequate time to effect a safe transfer to another hospital before delivery; or

  (b) That transfer to another hospital may pose a threat to the health or safety of the woman or unborn child.

DFS1540

Employee

The term Employee means a full-time employee of the Employer who is currently in Active Service. The term does not include employees who are part-time or temporary or who normally work less than 40 hours a pay period for the Employer.

DFS1427 DG

Employer

The term Employer means the Policyholder and all Affiliated Employers.

DFS212

Expense Incurred

An expense is incurred when the service or the supply for which it is incurred is provided.

DFS60

Free-Standing Surgical Facility

The term Free-Standing Surgical Facility means an institution which meets all of the following requirements:

- it has a medical staff of Physicians, Nurses and licensed anesthesiologists;
- it maintains at least two operating rooms and one recovery room;
- it maintains diagnostic laboratory and x-ray facilities;
- it has equipment for emergency care;
- it has a blood supply;
- it maintains medical records;
- it has agreements with Hospitals for immediate acceptance of patients who need Hospital Confinement on an inpatient basis; and
- it is licensed in accordance with the laws of the appropriate legally authorized agency.

DFS682

Herbal and Homeopathic Products

The terms Herbal and Homeopathic Products mean:

- products which are approved by the health plan are covered when obtained at the designated alternative medicine center.

Home Health Aide

The term Home Health Aide means a person who: (a) provides care of a medical or therapeutic nature; and (b) reports to and is under the direct supervision of a Home Health care Agency.

DFS62

Home Health Care Agency

The term Home Health Care Agency means a Hospital or a non-profit or public home health care agency which:

- primarily provides skilled nursing service and other therapeutic service under the supervision of a Physician or a Registered Graduate Nurse;
- is run according to rules established by a group of professional persons;
- maintains clinical records on all patients;
- does not primarily provide care and treatment of the mentally ill;

but only if, in those jurisdictions where licensure by statute exists, that Home Health Care Agency is licensed and run according to the laws that pertain to agencies which provide home health care.

DFS63

Home Health Care Plan

The term Home Health Care Plan means a plan for care and treatment of a person in his home. To qualify, the plan must be established and approved in writing by a Physician who certifies that the person would require confinement in a Hospital or Skilled Nursing Facility if he did not have the care and treatment specified in the plan.

DFS69

Hospice Care Program

The term Hospice Care Program means:

- a coordinated, interdisciplinary program to meet the physical, psychological, spiritual and social needs of dying persons and their families;
- a program that provides palliative and supportive medical, nursing and other health services through home or inpatient care during the illness;
- a program for persons who have a Terminal Illness and for the families of those persons.

DFS70

Hospice Care Services

The term Hospice Care Services means any services provided by: (a) a Hospital, (b) a Skilled Nursing Facility or a similar institution, (c) a Home Health Care Agency, (d) a Hospice Facility, or (e) any other licensed facility or agency under a Hospice Care Program.

DFS599

Hospice Facility

The term Hospice Facility means an institution or part of it which:

- primarily provides care for Terminally Ill patients;
- is accredited by the National Hospice Organization;
- meets standards established by CG; and
- fulfills any licensing requirements of the state or locality in which it operates.

DFS72

Hospital

The term Hospital means:

- an institution licensed as a hospital, which: (a) maintains, on the premises, all facilities necessary for medical and surgical treatment; (b) provides such treatment on an inpatient basis, for compensation, under the supervision of Physicians; and (c) provides 24-hour service by Registered Graduate Nurses;
- an institution which qualifies as a hospital or a tuberculosis hospital, and a provider of services under Medicare, if such institution is accredited as a hospital by the Joint Commission on the Accreditation of Hospitals;
- a Free-standing Surgical Facility.

The term Hospital will not include an institution which is exclusively a place for rest, a place for the aged or a nursing home.

DFS76

Hospital Confinement or Confined in a Hospital

A person will be considered Confined in a Hospital if he is:

- a registered bed patient in a Hospital upon the recommendation of a Physician;
- an outpatient in a Hospital because of: (a) chemotherapy treatment; or (b) surgery;
- receiving emergency care in a Hospital for an Injury, on his first visit as an outpatient within 48 hours after the Injury is received;
- Partially Confined for treatment of mental illness, alcohol or drug abuse or other related illness. Two days of being Partially Confined will be equal to one day of being Confined in a Hospital.

The term Partially Confined means continually treated for at least 3 hours but not more than 12 hours in any 24-hour period.

DFS128

Injury

The term Injury means an accidental bodily injury.

DFS147

Late Entrant

You are a Late Entrant for Employee or Dependent Insurance if:

(a) you have not been continuously covered for one year under a group medical insurance policy or a self-insured group medical plan, other than a policy issued by a state high risk insurance pool; and

(b) you have declined medical coverage for yourself or your Dependents through your Employer during the initial enrollment period, or have ended your coverage at any time; and

(c) you later request coverage for yourself or your Dependents.

The initial enrollment period must have been at least 30 days. An individual is not considered a Late Entrant if one of the following applies:

1. The person, at the time of the initial enrollment period, was covered under a prior plan. "Prior plan" means a public or private group medical insurance policy or self-insured group medical plan.
2. The person lost coverage under the prior plan due to the Employee's termination of employment or eligibility, the termination of the prior plan's coverage, the death of the spouse, or divorce.
3. The person requests enrollment within 30 days after the termination of coverage provided under the prior plan.
4. The person is employed by an Employer that offers multiple medical plans and the person elects a different plan during an open enrollment period.
5. A court orders that coverage be provided for a spouse or minor child under a covered Employee's medical plan and the Employee requests enrollment within 30 days after the court order is issued.

"Continuously covered" means the person is covered at the beginning and the end of the period and has not had any

breaks in coverage during the period totaling more than 31 days.

DFS1034

Medicaid

The term Medicaid means a state program of medical aid for needy persons established under Title XIX of the Social Security Act of 1965 as amended.

DFS192

Medicare

The term Medicare means the program of medical care benefits provided under Title XVIII of the Social Security Act of 1965 as amended.

DFS149

Necessary Services and Supplies

The term Necessary Services and Supplies includes:

- any charges, except charges for Bed and Board, made by a Hospital on its own behalf for medical services and supplies actually used during Hospital Confinement;
- any charges, by whomever made, for licensed ambulance service to or from the nearest Hospital where the needed medical care and treatment can be provided; and
- any charges, by whomever made, for the administration of anesthetics during Hospital Confinement.

The term Necessary Services and Supplies will not include any charges for special nursing fees, dental fees or medical fees.

DFS151

Nurse

The term Nurse means a Registered Graduate Nurse, a Licensed Practical Nurse or a Licensed Vocational Nurse who has the right to use the abbreviation "R.N.," "L.P.N." or "L.V.N."

DFS155

Participating Provider

The term Participating Provider means:

- an institution, facility or agency which has entered into a contract with a Preferred Provider Organization (referred to as the PPO) to provide medical services at a predetermined cost in accordance with the agreement between CG and the PPO.
- a health care professional who has entered into a contract with a PPO to provide medical services at predetermined fees as negotiated by CG and that PPO.

The providers qualifying as Participating Providers may change from time to time. A list of the current Participating Providers will be provided by your Employer.

DFS162

Physician

The term Physician means a licensed medical practitioner who is practicing within the scope of his license and who is licensed to prescribe and administer drugs or to perform surgery. It will also include any other licensed medical practitioner whose services are required to be covered by law in the locality where the policy is issued if he is:

- operating within the scope of his license; and
- performing a service for which benefits are provided under this plan when performed by a Physician.

DFS164

Reasonable and Customary Charge

A charge will be considered Reasonable and Customary if:

- it is the normal charge made by the provider for a similar service or supply; and
- it does not exceed the normal charge made by most providers of such service or supply in the geographic area where the service is received, as determined by CG.

To determine if a charge is Reasonable and Customary, the nature and severity of the Injury or Sickness being treated will be considered.

DFS527

Sickness - For Medical Insurance

The term Sickness means a physical illness. It also includes pregnancy. Expenses incurred for routine Hospital and pediatric care of a newborn child prior to discharge from the Hospital nursery will be considered to be incurred as a result of Sickness.

DFS531

Skilled Nursing Facility

The term Skilled Nursing Facility means a licensed institution (other than a Hospital, as defined) which specializes in:

- physical rehabilitation on an inpatient basis; or
- skilled nursing and medical care on an inpatient basis;

but only if that institution: (a) maintains on the premises all facilities necessary for medical treatment; (b) provides such treatment, for compensation, under the supervision of Physicians; and (c) provides Nurses' services.

DFS193

Specialist

The term Specialist means a Physician who provides specialized services, and is not engaged in general practice, family practice, internal medicine, obstetrics/gynecology or pediatrics.

DFS1429

Terminal Illness

A Terminal Illness will be considered to exist if a person becomes terminally ill with a prognosis of six months or less to live, as diagnosed by a Physician.

DFS197

Urgent Care

Urgent Care is medical, surgical, Hospital and related health care service and testing which is provided to treat a condition that is: (1) less severe than an Emergency Medical Condition; (2) requires immediate medical attention; and (3) is unforeseen. Care which could have been foreseen as needed before leaving the provider network area where the insured ordinarily receives and/or was scheduled to receive services does not meet the definition of Urgent Care. Such foreseeable care includes, but is not limited to, delivery beyond the 35th week of pregnancy, dialysis, scheduled medical treatments or therapy, or care received after a Physician's recommendation that the insured should not travel due to any medical condition.

DFS1541

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